# Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
This renewal application does include substantive changes to the performance measures. It does reflect new federal managed care regulations for processing member grievance and appeals through managed care organizations (MCO's).https://wms-mmdl.cms.gov/WMS/faces/protected/pageOne.jsp#

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

A. The **State** of **Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Home and Community Based Services - Elderly Waiver**

C. **Type of Request: renewal**

**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ 3 years ◉ 5 years

**Original Base Waiver Number: IA.4155**
**Draft ID: IA.006.06.00**

D. **Type of Waiver** *(select only one)*:
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
08/01/18

## 1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Iowa High Quality Healthcare Initiative

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☑ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. **Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Waiver Program Summary

The goal of the Iowa HCBS Elderly waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible members may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying at their local DHS office or through the online DHS benefits portal. Each individual applying for elderly waiver services must meet the nursing facility or skilled nursing facility level of care. IME's

Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care revaluations for fee-for-service members. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. This waiver does not have a wait list.

If the applicant is deemed waiver eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the member will have the option to choose between various traditional and self-directed services.

Services include adult day health, assisted living service, case management, homemaker, respite, home health aide services, nursing services, assistive devices, chore services, consumer directed attendant care, home and vehicle modification, home-delivered meals, mental health outreach, nutritional counseling, personal emergency response or portable locator system, senior companion, and transportation. Financial management services, independent support brokerage service, self-directed personal care, individual directed goods and services, and self-directed community and employment supports are available for the members who chose to self-direct their services.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa is to reduce waitlists and offer a more uniform and equitable system of community support delivery to memberss qualifying for this Waiver.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (•) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- ☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

*Note: Item 6-I must be completed.*

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Mental Health Planning Council meets monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including members and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council. The IME also provides notice of applications and amendments by including notice in the IME e-News emails and on the IME website.

IME used the following processes to secure public input into the development of the Waiver Renewal Application:

1) IME Website Posting - The public notice and the Waiver Renewal Application was posted to the DHS IME Website under the category, News & Initiatives (https://dhs.iow.gov/public-notices/XXXXXX. The public posting period began XXXXXXXX, 2018 and ended XXXXXXX, 2018. The Waiver program manager XXXXX receive public comments during this period.

2) DHS Field Office Posting - IME provides notification to the DHS Field Office, which in turn, notifies each DHS Field Office to post the Waiver Public Notice and to provide a copy of the CMS Waiver Renewal Application for any public request. The public posting period was the same for this process. The Waiver program manager XXXXX receive public comments.

3) IME Public Notice Subscribers - Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the IME Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver renewals. The public posting period was the same for this process. The Waiver program manager XXXXXX receive public comments.

4) Iowa Tribal Nations Notification - The IME Tribal Nations liaison notified all Nation governments by email on XXXXXX, 2018. The comment period ended on XXXXXX, 2018. The liaison XXXXX receive any comments or questions during this period.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Leann

**First Name:** Howland

**Title:** Policy program manager

**Agency:** Iowa Medicaid Enterprise

**Address:** 100 Army Post Road

**Address 2:**

**City:** Des Moines

**State:** **Iowa**

**Zip:** 50315

**Phone:** (515) 256-4642 **Ext:** ☐ **TTY**

**Fax:** (515) 256-1306

**E-mail:** lhowlan@dhs.state.ia.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** Iowa

**Zip:**

**Phone:** **Ext:** TTY

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

Submission Date:

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Iowa

Zip:

Phone: Ext: TTY

Fax:

E-mail:

## Attachments

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- **Replacing an approved waiver with this waiver.**
- **Combining waivers.**
- **Splitting one waiver into two waivers.**
- **Eliminating a service.**
- **Adding or decreasing an individual cost limit pertaining to eligibility.**
- **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- **Reducing the unduplicated count of participants (Factor C).**
- **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The numbers of unduplicated members and the number of members served at any point in time are held at the current status quo. At the time of the last amendment both sets of numbers were projected increases, but those increases were not realized.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Iowa received the initial approval from CMS on August 6, 2016 for the Iowa Home and Community Based Settings Transition Plan. Iowa assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Section 1: Assessment
Iowa proposes a multifaceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general categories (not specific providers or locations) that are likely to be in compliance; not in compliance; presumed to be non-HCBS; or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS settings during provider enrollment and re-enrollment; evaluating settings through the existing HCBS quality assurance onsite review process and the provider self-assessment process; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver participants.

10/1/2014 - 10/31/2014: Settings Analysis - State identified HCBS settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into categories (Yes - settings fully compliant, Not Yet - settings that will comply with changes, Not Yet - setting is presumed non-HCBS but evidence may be presented for heighted scrutiny review, and No - setting do not comply) The Iowa HCBS Settings Analysis is being submitted as one component of the transition plan.

12/1/2014 - 12/31/2014: Provider Enrollment Processes - State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening by the Iowa Medicaid Enterprise (IME), provider credentialing by the managed care behavioral health organization (BHO), and HCBS provider certification by the HCBS Quality Oversight unit.

5/1/2015 - 12/31/2015: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses - State will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentration of HCBS.

12/1/2014 - ongoing: Onsite assessment - The State will incorporate review of settings into the review tools used by the HCBS Quality Oversight Unit for on-site reviews. Settings will be assessed during recertification reviews, periodic reviews,

focused reviews, and targeted reviews. State will identify providers with sites of service that have the characteristics of HCBS or the qualities of an institution.

10/1/2014 - ongoing: Enrolled HCBS providers self-assessment - The state will modify the Provider Quality Management Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. The annual self-assessment will be released to providers annually on October 1 and due to IME annually on December 1, with results compiled by February 28. The State will release the "Iowa Exploratory Questions for Assessment of HCBS Settings" document to assist providers in identifying the expected characteristics of HCBS.

8/1/2014 - ongoing: Other projects collecting HCBS setting data - State provider association will provide information and input from residential providers to the state.
12/1/2014 - ongoing: Iowa Participant Experience Survey (IPES) - State will continue to monitor IPES results to flag member experience that is not consistent with assuring control over choices and community access.

5/1/2015 - By 3/17/2019: Onsite Assessment Results Report - State compiles and analyzes findings of onsite assessments annually by July 31, with the final report completed by 3/17/19. Findings will be presented to Iowa DHS leadership and stakeholders.

Section 2: Remediation Strategies
Iowa proposes a remediation process that will capitalize on existing HCBS quality assurance processes including provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Iowa will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings timely may be subject to sanctions ranging from probation to disenrollment.

6/1/2014 - 7/31/2016: Informational Letters - State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO and MCO will provide the same information to provider network.

12/1/2014 - 7/31/2015: Iowa Administrative Code - State will revise administrative rules chapters 441-77, 78, 79, and 83, to reflect federal regulations on HCBS settings. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of member control of their environment and access to community. BHO will develop the same standards for provider network. MCOs will develop the same standards for provider network.

8/1/2015 - 12/31/2015: Provider Manual Revisions - State will revise HCBS provider manual Chapter 16K to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. MCOs will incorporate the same information into relevant provider network manuals.

12/1/2014 - ongoing: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment - IME Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that HCBS settings are evaluated when appropriate. When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements.

12/1/2014 - ongoing: Provider Assessment Findings - State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.

12/1/2014 - 3/16/2019: Provider Individual Remediation - HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis. Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review.

12/1/2014 - 3/16/2019: Data Collection - State, BHO and MCOs will collect data from reviews, technical assistance,

updates, etc. to track status of remediation efforts. Data will be reported on a regular basis or ad hoc to DHS management and CMS.

12/1/2014 - 3/1/2019: Onsite Compliance Reviews - State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.

12/1/2014 - 3/16/2019: Provider Sanctions and Disenrollments - State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.

12/1/2014 - 3/16/2019: Member Transitions to Compliant Settings - If relocation of members is necessary, the state will work with case managers, service workers, and care coordinators to ensure that members are transitioned to settings meeting HCBS Setting requirements. Members will be given timely notice and due process, and will have a choice of alternative settings through a person centered planning process. Transition of members will be comprehensively tracked to ensure successful placement and continuity of service.

Section 3: Public Comment

Iowa proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments, and through taking public comments directly by mail. Iowa has also previously held a comment period in November 2014 which included solicitation of comments through stakeholder forums. In addition to posting the transition plan and related materials on the Iowa Medicaid website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, NAMI Iowa, ASK Resource Center, Area Agencies on Aging, County Case Management Services, and MHDS Regional Administrators.

3/9/2015 - 3/13/2015: Announcement of Public Comment Period - State released a White Paper, the Draft Transition Plan, and Draft Settings Analysis on the state website. Informational Letters were released and sent to all HCBS waiver providers, case managers and DHS service workers. Stakeholders (listed above) were contacted directly to inform them of the public comment period. A dedicated email address (HCBSsettings@dhs.state.ia.us) was established to receive public comments. Tribal notices were sent. Notices were filed in newspapers. Printed versions were made available in DHS local offices statewide, along with instructions on submitting comments via mail.

3/16/2015 - 4/15/2015: Public Comment Period for Proposed Transition Plan - State will share transition plan with the public in electronic and non-electronic formats, collect comments, develop state responses to public comments, and incorporate appropriate suggestions into transition plan. The Response to Public Comments document will be posted to the DHS website and a summary provided to CMS. Previous comment periods were held in May 2014 and November 2014 which included stakeholder forums.

4/15/2015 - 3/16/2019: Public Comment Retention - State will safely store public comments and state responses for CMS and public consumption.

4/15/2015 - 3/16/2019: Posting of Transition Plan Iterations - State will post each approved iteration of the transition plan to its website.

7/1/2015 - By 3/17/2019: Assessment Findings Report - State shares the findings of the onsite assessment annually by July 31.

Iowa HCBS Settings Analysis - This Settings Analysis is general in nature and does not imply that any specific provider or location is noncompliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan, including but not limited to onsite reviews, provider annual self-assessments, IPES data, provider surveys, and GIS analysis.

Category: YES – Settings presumed fully compliant with HCBS characteristics
--Member owns the housing, or leases housing which is not provider owned or controlled.

Category: NOT YET – Settings may be compliant, or with changes will comply with HCBS characteristics

--Residential Care Facilities (RCFs) of any size
--Apartment complexes where the majority of residents receive HCBS
--Provider owned or controlled housing of any size
--Multiple locations on the same street operated by the same provider (including duplexes and multiplexes)
--Assisted Living Facilities
--Services provided in a staff member's home (except Respite)
--Day program settings located in a building that also provides other disability-specific services, or where provider offices are located.

Category: NOT YET - Setting is presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review
--Located in a building that also provides inpatient institutional treatment
--Any setting on the grounds of or adjacent to a public institution
--Settings that isolate participants from the broader community
Category: NO – Settings do not comply with HCBS characteristics
--Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite)
--Nursing Facilities/Skilled Nursing Facilities
--Hospitals
--Institutions for Mental Disease (IMD)

Process:
Public comment was taken from March 16, 2015 through April 15, 2015. The transition plan was posted on the IME website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The transition plan has been available at that location since March 12, 2015. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on March 9, 2015. The transition plan was available for non-electronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally-recognized tribes on March 9, 2015.

Summary of Comments:
Comments that resulted in changes to the transition plan:
There were no comments received that resulted in changes to the transition plan.

Comments for which the State declined to make changes to the transition plan or settings analysis document:
There were numerous comments submitted which did not ask for changes to the transition plan, but rather were seeking clarification or interpretation of the federal regulation or posed operational questions about how the state would carry out activities in the transition plan.

Four commenters suggested that various aspects of the transition plan need to be updated to reflect the role that the Managed Care Organizations (MCOs) will have related to the Iowa High Quality Health Care Initiative. The state declined to makes changes based on the comment and explained in the response that Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future, and that there will be another public comment period related to those amendments at that time.

Two commenters expressed concern about engaging consumers, families and advocates in the transition plan. The state declined to make changes based on the comment and explained the various ways that input from consumers and advocates has been sought in the development of the plan and expressed that consumer and advocate involvement will continue throughout implementation.

One commenter objected that Iowa's transition plan includes a "rebuttable presumption" that residential care facilities, provider-owned housing, assisted living on a nursing facility campus and any location adjacent to an institutional setting is "presumptively non-HCBS". The state declined to make a change because the commenter's reading of the plan was not correct. The state clarified in our response that in our settings analysis the only settings included in the category of "presumed non-HCBS" are those that are set out in the federal regulation, which includes settings located in a building that also provides inpatient institutional treatment, settings on the grounds of or adjacent to a public institution, or settings that isolate participants from the broader community.

One commenter asked that the role of the state's Mental Health and Disability Services (MHDS) Regions be included in the

plan. The state declined to make this change, explaining that the MHDS Regions are already listed as stakeholders in the plan.

One commenter asked that the plan be changed to eliminate the distinction between provider owned and controlled housing, as the commenter believed this had been eliminated from the regulation. The state declined to make this change and explained in the response that the federal regulation does still set out additional requirements for provider owned and controlled settings.

One commenter suggested that the "players" column which existed in an early draft of the transition plan, but was later removed should be added back into the plan. The state declined to make this change and explained in the response that the responsibility for completion of the activities listed in the transition plan lies with the IME, and other stakeholders are already noted in the description column for each item or in the explanatory narrative at the top of each section.

One commenter expressed that activities within the transition plan should not have end dates listed as "ongoing". The state declined to make this change and explained in the response that our approach utilizes an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline, and our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis.

One commenter suggested that the actions or omissions that would trigger the requirement of a corrective action plan (CAP) should be listed in the transition plan. The state declined to make this change, explaining that any finding of noncompliance will trigger a CAP.

One commenter suggested that in regard to provider remediation, rather than the State allowing "reasonable time frames" for large infrastructure changes, the State should impose specific timeframes and deadlines. The state declined to make a change because we believe the commenter misunderstood the intent of the item. Our response to the comment explained that the timeframes that will be set out in any given CAP will be specific deadlines for that provider and location. The "reasonable timeframes" language needs to be read in the context of the previous sentence in the plan which indicates that in reviewing a CAP, the state will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The original document is too big to include here. Please see the HCBS Statewide Transition Plan approved on August 9, 2016 on this link:
https://dhs.iowa.gov/sites/default/files/Approved_Initial_STP_Submitted.pdf

The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   **Iowa Medicaid Enterprise, Bureau of Long Term Care**
   *(Do not complete item A-2)*

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   *(Complete item A-2-a).*

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*:

   MCO -

   MCOs will generally be responsible for delivering covered benefits, including physical health, behavioral health and LTSS in a highly coordinated manner. Specific functions include, but are not limited to, the following:

   - Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
   - Conducting comprehensive needs assessments, developing service plans, coordinating care, and authorizing and initiating waiver services for all members;
   - Conducting level of care reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the level of care;
   - Delivering community-based case management services and monitoring receipt of services;
   - Contracting with an entity or entities for financial management services to assist members who elect self-direction (i.e., Iowa's "Consumer Choices Option");
   - Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
   - Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
   - Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice from trained medical professionals;
   - Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
   - Operating an incident reporting and management system;
   - Maintaining a utilization management program;
   - Developing programs and participating in activities to enhance the general health and well-being of members; and
   - Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

   FFS

   Those memberss who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through the fee-for-service delivery system. As such, the State will continue to contract with the following entities to perform certain waiver functions:

   Member Services (Maximus) as part of a contract with IME to disseminate information to Medicaid beneficiaries and provide support. Additionally, Member Services provides clinical review to identify beneficiary population risks such that additional education, program support, and policy revision can mitigate risks to the beneficiary when possible.

   Medical Services Unit (MSU) (Telligen) conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. In addition, MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

   Home and Community Based Services Waiver Quality Assurance (Telligen) reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and technical assistance

to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator (Optum) reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services (Maximus) coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with the IME's Individualized Services Information System (ISIS).

Provider Cost Audit (Myers and Stouffer) determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

Revenue Collections Unit (HMS) performs recovery of identified overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

Pharmacy (Gould Health Systems) oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. The Pharmacy Medical group performs drug Prior Authorization with medical professionals who evaluate each request for the use of a number of drugs.

Point-of-Sale (POS) (Gould Health Systems) is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

All contracted entities including the Medicaid Department conduct training and technical assistance concerning their particular area of expertise concerning waiver requirements. Please note that ultimately it is the Medicaid agency that has overall responsibility for all of the functions while some of the functions are performed by contracting agencies. In regards to training, technical assistance, recruitment and disseminating information, this is done by both the Medicaid agency and contracted agencies throughout regular day-to-day business.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ◉ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    *Specify the nature of these agencies and complete items A-5 and A-6:*

  - ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)**

under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
IME Medical Policy Staff, through DHS, is responsible for oversight of the contracted entities. The DHS IME is the State Agency responsible for conducting the operational and administrative functions of the waiver.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
IME is an endeavor that unites State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

All contracted entities are assigned a State-employed contract manager, are assessed through their performance-based contracts, and are required to present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Monthly meetings are designed to facilitate communication among the various business units within the IME to ensure coordination of operations and performance outcomes. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a MCO Oversight and Supports Bureau within IME to provide comprehensive program oversight and compliance. Specifically, the Bureau Chief, reporting directly to the Medicaid Director, is responsible for directing the activities of bureau staff. Each MCO account manager will oversee contract compliance for one designated MCO. The MCO account managers will serve as liaisons between the MCOs and the State, and will be the point of contact coordinating communications and connecting subject matter experts. The new Bureau will work directly with the IME Program Integrity Unit, which oversees compliance of all IME providers, including the MCOs.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| Participant waiver enrollment | ✓ | ✓ |
| Waiver enrollment managed against approved limits | ✓ | ✓ |
| Waiver expenditures managed against approved levels | ✓ | ✓ |
| Level of care evaluation | ✓ | ✓ |
| Review of Participant service plans | ✓ | ✓ |
| Prior authorization of waiver services | ✓ | ✓ |
| Utilization management | ✓ | ✓ |
| Qualified provider enrollment | ✓ | ✓ |
| Execution of Medicaid provider agreements | ✓ | ✓ |
| Establishment of a statewide rate methodology | ✓ | ✓ |
| Rules, policies, procedures and information development governing the waiver program | ✓ | ✓ |
| Quality assurance and quality improvement activities | ✓ | ✓ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

i. **Performance Measures**

***For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application.*** *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

***Where possible, include numerator/denominator.***

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**MCO performance monitoring**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>MCO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MCO performance monitoring**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>MCO | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| | ☐ Other<br>Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| Responsible Party*(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☑ Other<br>Specify:<br>Contracted Entity and MCOs | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ No

○ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

# Appendix B: Participant Access and Eligibility

## B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☑ Aged or Disabled, or Both - General | | | | | |
| | ☑ | Aged | 65 | | ☑ |
| | ☐ | Disabled (Physical) | | | |
| | ☐ | Disabled (Other) | | | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☐ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☐ | Autism | | | ☐ |
| | ☐ | Developmental Disability | | | ☐ |
| | ☐ | Intellectual Disability | | | ☐ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

# Appendix B: Participant Access and Eligibility

## B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  **The limit specified by the State is** *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    *Specify:*

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

  [ ]

  **The cost limit specified by the State is** *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    **The dollar amount** *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

      [ ]

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| Year 1 | 12237 |
| Year 2 | 12237 |

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| Year 3 | 12237 |
| Year 4 | 12237 |
| Year 5 | 12237 |

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| Year 1 | 9200 |
| Year 2 | 9200 |
| Year 3 | 9200 |
| Year 4 | 9200 |
| Year 5 | 9200 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

*Select one*:

- (•) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Applicants are accepted on a first come first served basis based upon the date the waiver application is received by the department. Applicants must meet the established nursing facility or skilled nursing level of care. This waiver does not have a waiting list.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

Parents and other caretaker relatives specified at 42 CFR §435.110; pregnant women specified at 42 CFR §435.116; and children specified at 42 CFR §435.118.

All other mandatory and optional categorically needy groups under the Medicaid State Plan are included.

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies:*

- [x] **A special income level equal to:**

*Select one:*

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

*Select one:*

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

b. **Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver

services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. **Allowance for the needs of the waiver participant** (*select one*):

- ○ **The following standard included under the State plan**

  *Select one:*

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:

    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:

  - ○ **A percentage of the Federal poverty level**

    Specify percentage:

  - ○ **Other standard included under the State Plan**

    *Specify:*

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

  *Specify:*

- ◉ **Other**

  *Specify:*

  The following formula is used to determine the needs allowance: 300% of the SSI benefit and for participants who have a medical assistance income trust (Miller Trust) an additional $10 (or higher if court ordered) to pay for administrative costs.

  DHS determines patient liability. For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

  The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When

capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

**ii. Allowance for the spouse only** (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

A deduction for the maintenance needs of a spouse is allowed only when the institutionalized spouse has a Miller Trust in place.

**Specify the amount of the allowance** (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

For members who have a medical assistance income trust (Miller Trust) allowance for the maintenance needs of the spouse to up to the medically needy income standard.

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

The only time a deduction is allowed for the maintenance needs of the family is when the member has a medical assistance income trust (MAIT). Otherwise, if the member doesn't have a MAIT the only deduction they are allowed for client participation is up to the 300% of the SSI limit for one person.

There is no deduction for the community spouse if there is no Miller Trust. For members with a Miller Trust the following deductions are allowed in order: (1) $10 for trust administrative fee; (2) member's personal needs allowance (up to 300% of SSI for one person); (3) maintenance fee for the spouse and dependents living at home; and (4) unmet medical needs deduction.

- **Other**

*Specify:*

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. **Allowance for the personal needs of the waiver participant**

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

*Specify formula:*

● **Other**

*Specify:*

The following formula is used to determine the needs allowance: 300% of the SSI benefit and for members who have a medical assistance income trust (Miller Trust) an additional $10 (or higher if court ordered) to pay for administrative costs.

DHS determines patient liability. For managed care members with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

● **Allowance is the same**

○ **Allowance is different.**

*Explanation of difference:*

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

e. **Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

f. **Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

g. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

HCBS waiver services must be accessed at least once every calendar quarter by the member. Case managers, integrated health home care coordinators, and community-based case managers are required to make monthly contacts, either face to face or telephonic, regarding each member in order to establish access to services and to ensure the authorized services are provided as outlined in the member's service plan to ensure the member's health, safety and welfare.

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- **Other**

*Specify:*

The IME MSU is responsible for determining the initial level of care evaluation for waiver enrollment with the input of the case manager, integrated health home care coordinator, or community-based case manager, medical professionals, and other appropriate professionals. For fee-for-service members, the reevaluation is also conducted by the IME MSU. MCOs are responsible for reevaluations of their members. The IME MSU reviews and approves all reevaluations that indicate a change in the member's level of care.

MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. Upon identification the MCO completes the initial level of care assessment with the IME MSU maintaining final review and approval authority.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Trained assessors perform the initial evaluation/assessment by use of the Core Standardized Assessment tool approved by the State. The IME requires that individuals making level of care determinations be licensed registered nurses. If the RN is unable to approve level of care, then the Physician Assistant or Physician makes the final level of care determination.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

IME Medical Services uses the interRAI - Home Care (HC)assessment tool to determine level of care for the Elderly Waiver. The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services.

The interRAI HC can be used to assess persons with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). Areas of review include: (1) cognitive; (2) mood and behavior patterns; (3) physical functioning – mobility; (4) skin condition; (5) pulmonary status; (6)

continence; (7) dressing and personal hygiene – ADLS; (8) physical functioning – eating; (9) medications; (10) communication/hearing/vision patterns; and (11) prior living - psychosocial.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The interRAI HC Assessment Form is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items also identify persons who could benefit from further evaluation of specific problems of risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol. The CAPS contain general guidelines for further assessment

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care.
These include:
*Scales for ADLs, cognition, communication, pain, depression, and medical instability
*Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
*Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)
*A quality monitoring system (Home Care Quality Indicators, or HCQIs)
*A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)

IME Medical Services may request additional information from the case manager, integrated health care coordinator, or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

It is the responsibility of the case manager, health home coordinator, or community-based case manager to assure the assessment is initiated as required to complete the initial level of care determination. For FFS members, the initial assessment is completed by the Core Standardized Assessment(CSA) contractor Telligen and sent to the case manager, or IHH care coordinator, who uploads the assessment to the IME MSU. For MCO members, the MCO is responsible to ensure the CSA is completed, and then uploaded to the IME MCU. The IME MSU is responsible for determining the level of care based on the completed assessment tool and supporting documentation from medical professionals.

The Continued Stay Review (CSR) is completed annually and when the a case manager or health home coordinator becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The CSR process uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the case manager or health home coordinator to assure the assessment is initiated as required to complete the CSR. For fee-for-service members, the ISIS system sends out a milestone 60 days prior to the CSR date to remind case managers and health home coordinators of the upcoming annual LOC process. The FFS CSA contractor completes these assessment, and the IME MSU conduct LOC redeterminations.

MCOs are responsible for conducting level of care reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the level of care or functional eligibility decision to the IME MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members into a Medicaid eligibility category. MCOs track and report level of care and

needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in level of care and DHS retains final level of care determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

MCOs are required to employ staff with the same professional credentials as required for FFS. Further, MCOs are contractually required to ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to: (i) contract requirements and State and Federal requirements specific to job functions; (ii) training on the MCOs policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Policies and Procedures Manuals must also be provided to the MCO's entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  *Specify the other schedule:*

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  *Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Reevaluations of fee-for-service members are tracked in the DHS Individualized Services Information System (ISIS). A reminder is sent out to the case manager or integrated health home care coordinator for the evaluation 60 days before the reevaluation is due. A CSR report is available through ISIS to track if reevaluations are overdue and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME. MCOs are responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member

level of care reevaluations must be completed within twelve (12) months of the previous evaluation. The LOC contractor reports monthly, quarterly and annually on the timeliness of the initial and annual reevaluations completed. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

Should MCO reevaluations not be completed in a timely manner, DHS may require corrective action(s) and implement intermediate sanctions in accordance with 42 CFR 438, Subpart I. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, a written warning, formal corrective action plan, withholding of full or partial capitation payments, suspending auto-assignment, reassigning an MCO's membership and responsibilities, appointing temporary management of the MCO's plan, and contract termination. In the event of non-compliance with reevaluation timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation documents for initial LOC determinations, and reevaluation documents exhibiting a change in LOC, are faxed to the IME MSU regardless of delivery system (i.e., FFS members and MCO members) and placed in "OnBase." OnBase is the system that stores documents electronically and establishes workflow.

In addition, the waiver member's case manager, integrated health home care coordinator, or community-based case manager is responsible for service coordination for each member. These providers maintain a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the memberwas receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all evaluations and reevaluations.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

***The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.***

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**LC-a1: IME will measure the number and percent of approved LOC decisions.**
**Numerator: # of completed LOC; Denominator: # of referrals for LOC.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO populations.**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>contracted entity | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**IME MQUIDS and OnBase**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 5% |
| ☑ **Other** Specify: Contracted Entity | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| | |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards.
Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| Responsible Party*(check each that applies)*: | Frequency of data aggregation and analysis *(check each that applies)*: |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☑ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ No
○ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

## B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. *informed of any feasible alternatives under the waiver; and*
ii. *given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHS is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in Olmsted v. L.C. As such, services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS.

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

The person-centered process is holistic in addressing the full array of medical and non-medical services and supports to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Moreover, members are given the necessary information and support to ensure their direction of the process to the maximum extent possible, and to empower them to make informed choices and decisions regarding the services and supports received.

FFS
During enrollment of fee-for-service members, ISIS requires that case managers (CM) and health home coordinators attest to having offered a choice between HCBS or institutional services. Choice is verified by : (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the member's choice with the income maintenance worker and the case manger or health home coordinator documents the conversation.

Further, there are waiver informational brochures available to share with memberss and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

MCO
MCO community case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.

As part of the 2017 EQR process, a focused study was conducted regarding Person Centered Care Planning processes of the MCOs. The EQR vendor conducted onsite visits to review MCO documentation of person centered care planning (including freedom of choice) for a sample of MCO members to verify that MCOs are maintaining records of such processes. The results of this study will be provided to the IME in Spring 2018. MCO account managers will then work with the MCOs to ensure that choice is documented as part of the overall process.

In addition, the IME Medical Services Unit (MSU)reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS Unit, during the IPES member telephone surveys, asks members if they are offered choice of

providers. The HCBS regional specialists (part of the HCBS QA Unit) as part of the IDT/CBCM Ride Along activity, identifies if provider choice is offered during the IDT meetings.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

FFS
Freedom of Choice forms for fee-for-service members is documented in member service plans and in ISIS. MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or representatives of the state and federal governments.

MCO
The 2017 External Quality Review (EQR) process included a focused study on the MCOs Person Centered Care Planning processes. The EQR vendor requests documentation of person centered care planning (including freedom of choice)for a sample of MCO members to verify that MCOs are maintaining records of such processes. The results of this study will be provided to the IME in Spring 2018. MCO account managers will then work with the MCOs to ensure that choice is documented as part of the overall process.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Iowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and members to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:
- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their vailability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

All applications and informational handouts are printed in Spanish. In addition, the contract with IME Member Services requires that a bilingual staff person be available to answer all telephone calls, emails and written inquires. They also work with interpreters if another spoken language is needed. All local DHS offices have access to a translator if a bilingual staff person is not available. DHS includes this policy as part of their Policy on Nondiscrimination that can be found in the DHS Title I General Departmental Procedures in the Department Employee Manual.

Locally, each county DHS office utilizes the resources that are available to them. For example, in larger metropolitan areas, local offices have staff that is fluent in Spanish, Bosnian, and Southeastern Asian languages. Some offices utilize translators from DHS Refugee Services. Other areas of the state have high Russian populations and access the translators in the area. All county offices have access to the Language Line service where they may place a telephone call and request a translator when one is not available at the local office. Medicaid members may call the IME Member Services unit with any questions relating to Medicaid, including waiver services. Member Services has translation capabilities similar to the local DHS offices and uses the Language Line to address any language when Member Services does not have an interpreter on staff.

MCOs must conform to DHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.

- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service
area).
- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).
- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

All MCO developed member communications, including substantive changes to previously approved communications, must be approved by DHS prior to use/distribution.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service |
|---|---|
| Statutory Service | Adult Day Health |
| Statutory Service | Case Management |
| Statutory Service | Homemaker |
| Statutory Service | Respite |
| Extended State Plan Service | Home Health Aide Services |
| Extended State Plan Service | Nursing Services |
| Supports for Participant Direction | Financial Management Service |
| Other Service | Assisted Living |
| Other Service | Assistive Devices |
| Other Service | Chore Services |
| Other Service | Consumer Directed Attendant Care-unskilled |
| Other Service | Consumer-directed attendant care - Skilled |
| Other Service | Home and Vehicle Modification |
| Other Service | Home Delivered Meals |
| Other Service | Independant Support Brokerage Service |
| Other Service | Individual Directed Goods and Services |
| Other Service | Mental Health Outreach |
| Other Service | Nutritional Counseling |
| Other Service | Personal Emergency Response or Portable Locator System |
| Other Service | Self Directed Community Support and Employment |
| Other Service | Self-directed Personal Care |
| Other Service | Senior Companion |
| Other Service | Transportation |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

04 Day Services

**Sub-Category 2:**

04050 adult day health

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Adult day care services provide an organized program of supportive care in a group environment to members who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Supports provided during day care would be ADLs and IADLs. Included are personal cares (IE: ambulation, toileting, feeding, medications) or intermittent health-related cares, not otherwise paid under other waiver or state plan programs.

Meals provided as part of these services shall not constitute a full nutritional day; each meal is to provide 1/3 of daily dietary allowances.

Transportation is not a required element of adult day services but if the cost of transportation is provided and charged to Medicaid, the cost of transportation must be included in the adult day health per diem.

Adult day care does not cover therapies: OT, PT or speech.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15-minutes (up to 4 units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day) or an extended day (8.25 to 12 hours per day).

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Adult Day Care Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Adult Day Health**

**Provider Category:**
Agency
**Provider Type:**
Adult Day Care Agencies
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Agencies that are certified by the Iowa Department of Inspections and Appeals. Iowa Administative Code 481-chapter 70:
"Accredited" means that the program has received accreditation from an accreditation entity recognized in

Department of Inspections (DIA) rules for Adult Day Service: CARF or a recognized accrediting entity designated by the Department of Inspections and Appeals (DIA).
"Nonaccredited" means that the program has been certified under the provisions by DIA but has not received accreditation from the accreditation entity recognized by DIA
NonAccredited program Application content:
70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable: a. The real estate owner or lessor; b. The lessee; and c. The management company responsible for the day-to-day operation of the program.
70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.
70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.
70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.
70.4(5) The policy and procedure for service plans.
70.4(6) The policy and procedure for addressing medication needs of participants.
70.4(7) The policy and procedure for accidents and emergency response.
70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.
70.4(9) The policy and procedure for activities.
70.4(10) The policy and procedure for transportation.
70.4(11) The policy and procedure for staffing and training.
70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.
70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.
70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).
70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).
70.4(16) The participant contractual agreement and all attachments.
70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.
70.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

**Other Standard** *(specify)*:

Providers must be:
(1) At least 18 years of age.
(2) Qualified by training
(3) Not the spouse or guardian of the member
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The adult day service agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 01 Case Management | 01010 case management |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Case Management services are activities that assist members in gaining access to needed medical,social,and other appropriate services. Case Management is provided at the direction of the member and the interdisplinary team.

Case Management includes:

1. Use of the comprehensive assessment of the member's needs
2. Development and imlementation of a service plan to meet those needs.
3. Coordination, authorization and monitoring of all services delivery.
4. Monitoring the member's health and welfare.
5. Evaluating outcome.
6. Periodic reassessment and revision of the service plan as needed but at least annually.
7. On going advocacy on behalf of the member.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Payment for FFS case management may not be made until the member is enrolled in the waiver. Payment can also only be made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least quarterly face to face contacts and monthly collateral contacts. A unit of service is 15 minutes.

**Service Delivery Method** *(check each that applies)*:

- ( ) **Participant-directed as specified in Appendix E**
- (✓) **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ( ) **Legally Responsible Person**

Relative

Legal Guardian

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Area Agency on Aging |
| Agency | Agency Certified through JCAHO |
| Agency | Council on Quality and Leadership |
| Agency | Agency with CARF Accreditation |
| Agency | Agency Certified through Chapter 24 |
| Agency | Public Health contract |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Area Agency on Aging

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

An Agency that is approved by the Department on Aging as meeting the standards for case management services in IAC 17- Chapter 21:

17—21.9(231) Personnel qualifications. After July 1, 2006, the following are minimum training, education and work history requirements for AAA and contract personnel in the CMPFE program:

21.9(1) Case manager qualifications for employment.

a. The case manager shall hold a bachelor's degree in the human services field. The case manager may substitute up to two years' full-time equivalent work experience in a human services field involving direct contact with people in overcoming social, economic, psychological or health problems for two years of the educational requirement; or

b. The case manager shall be currently licensed as a registered nurse in Iowa.

**Other Standard** *(specify)*:

A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1)Specific procedures to identify conflicts of interest.

(2)Procedures to eliminate any conflict of interest that is identified.

(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:

(1)That entity must also meet the provider qualifications in this subrule; and

(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**
Agency
**Provider Type:**
Agency Certified through JCAHO
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
An Agency or individual that is accredited through Joint Commission on Accreditation of Health Care Organizations (JCAHO) to provide case management. Provider must attach a current certificate of accreditation and most recent survey report. IAC 441-77.33(21).
**Other Standard** *(specify):*
A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:
(1)Specific procedures to identify conflicts of interest.
(2)Procedures to eliminate any conflict of interest that is identified.
(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:
(1)That entity must also meet the provider qualifications in this subrule; and
(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**
Agency
**Provider Type:**
Council on Quality and Leadership
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
An agency or individual accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management. IAC 441-77.33(21).
**Other Standard** *(specify):*
A case management provider shall not provide direct services to the member. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest.

A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:
(1)Specific procedures to identify conflicts of interest.
(2)Procedures to eliminate any conflict of interest that is identified.
(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:
(1)That entity must also meet the provider qualifications in this subrule; and
(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**
Agency

**Provider Type:**
Agency with CARF Accreditation

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
An Agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for Case Management services. They must attach a current certification and most recent CARF survey report. IAC 441-77.33(21).

**Other Standard** *(specify):*
A case management provider shall not provide direct services to the member. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest.

A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:
(1)Specific procedures to identify conflicts of interest.
(2)Procedures to eliminate any conflict of interest that is identified.
(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:
(1)That entity must also meet the provider qualifications in this subrule; and
(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**
Agency

**Provider Type:**
Agency Certified through Chapter 24

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
An Agency that that is accredited by the mental health, mental retardation, developmental disabilites, and brain injury commission as meeting the standards for case management services in IAC 441 Chapter 24:

"Qualified case managers and supervisors" means people who have the following qualifications:
1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery ofservicesto the population groupsthat the person is hired as a case manager or case management supervisor to serve; or
2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

**Other Standard** *(specify):*

A case management provider shall not provide direct services to the member. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest.

A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:
(1)Specific procedures to identify conflicts of interest.
(2)Procedures to eliminate any conflict of interest that is identified.
(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:
(1)That entity must also meet the provider qualifications in this subrule; and
(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Public Health contract

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

An agency or individual that is authorized to provide similar services through a contract with the department of public health for local public services and that:
1. meets the qualifications for case managers in IAC 641- 80.3(7)and
2. provides a current IDPH contract number.

80.3(7) Coordination of case management services.
a. The authorized agency is responsible for determining the ability of a job applicant to meet the requirements outlined in the job description. At a minimum, individuals responsible for coordinating case management services shall meet one of the following criteria:
(1) Be a registered nurse (RN) licensed to practice nursing in the state of Iowa; or
(2) Possess a bachelor's degree with at least one year of experience in the delivery of services to vulnerable populations; or
(3) Be a licensed practical nurse (LPN) licensed to practice nursing in the state of Iowa.
b. A home care aide with an equivalent of two years' experience may be delegated coordination of case management services as long as a qualified individual who meets one of the criteria in paragraph 80.3

(7)"a" retains responsibility and provides supervision.
c. Individuals who are responsible for the coordination of case management services on or before June 30, 2015, are exempt from the criteria in paragraph 80.3(7)"a."
d. Case management services shall be provided at the direction of the consumer. The documentation to support the case management services shall include at a minimum:
(1) An initial assessment of the consumer's needs;
(2) Development and implementation of a service plan to meet the identified needs;
(3) Linking of the consumer to appropriate resources and natural supports; and
(4) Reassessment and updating of the consumer's service plan at least annually
**Other Standard** *(specify):*
A case management provider shall not provide direct services to the member. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management members to be a conflict of interest.

A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver members. The provider must have written conflict of interest policies that include, but are not limited to:
(1)Specific procedures to identify conflicts of interest.
(2)Procedures to eliminate any conflict of interest that is identified.
(3)Procedures for handling complaints of conflict of interest, including written documentation.

If the case management provider organization subcontracts case management services to another entity:
(1)That entity must also meet the provider qualifications in this subrule; and
(2)The contractor is responsible for verification of compliance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Statutory Service

**Service:**
Homemaker

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08050 homemaker |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Homemaker services are services that are provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. Components of the service are directly related to the care of the members and may include: essential shopping, limited house cleaning and meal preparation.

Homemaker services cannot be duplicative of other waiver service. Case managers, CBSM, or integrated health home care coordinators are responsible to ensure that if the services authorized under Homemaker are repeated on the CDAC agreement that the member and both providers understand the provided services can not be duplicated. In addition, IME asserts that no two similiar waiver services can be provided at the same time. The case manager, CBCM, or integrated health home care coordinator is responsible to monitor service provision on an ongoing basis.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15 minutes. The members' plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan. The Case Manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies):*

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Homemaker**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
In accordance with IAC 441-Chapter 77: Home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate with the Medicare program (Title XVIII of the Social Secrity Act sections 1861(o)and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 09 Caregiver Support | 09011 respite, out-of-home |
| **Category 2:** | **Sub-Category 2:** |
| 09 Caregiver Support | 09012 respite, in-home |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite is to enable the member to remain in the member's current living situation.

Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on temporary leave of absence.

Staff to member ratios shall be appropriate to the member's needs as determined by the member's interdisciplinary team. The interdisciplinary team shall determine if the member shall receive receive basic individual respite, specialized respite or group respite. Basic individual respite is provided on a staff-to member ratio of one to one to members without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse; group respite is provided on a staff to member ratio of one to many; specialized respite is provided on a staff to member ratio of one to one to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse. The payment for respite is connected to the staff to member ratio. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

Overlapping of services is avoided by the use of a case manager, CBCM, or integrated health home care coordinator who manages all services and the entry into the ISIS system.

Respite may be provided in the home, camp setting, and nursing facility.

Federal Financial Participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility apoproved by the State that is not a private residence.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A unit of service is 15 minutes. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

For self direction: The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The amount, frequency, or duration of the self-directed respite service is the same as respite that is not self-directed.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Assisted Living Programs |
| Agency | Camps |
| Agency | Home Health Agency |
| Agency | Nursing facilities and hospitals |
| Agency | Adult Day Care Providers |
| Agency | Home Care Agencies |
| Agency | Respite Providers Certified under the HCBS ID waiver |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency

**Provider Type:**
Assisted Living Programs

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:
Assisted Living programs certified by the Department of Inspections and Appeals as defined in IAC 481 Chapter 69.2.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable

requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.
**Other Standard** *(specify):*
Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.
-The member's medical issues, including allergies.
-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.
Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the cmember's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
Camps
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
In accordance with Iowa Administrative Code 441-77.33(6) Respite care providers.
77.33(6)a.(3) Camps certified by the American Camping Association.

The ACA-Accreditation Program:
• Educates camp owners and directors in the administration of key aspects of camp operation, program quality, and the health and safety of campers and staff.
• Establishes guidelines for needed policies, procedures, and practices for which the camp is responsible for ongoing implementation.
• Assists the public in selecting camps that meet industry-accepted and governmentrecognized standards. ACA's Find a Camp database provides the public with many ways to find the ideal ACA-accredited camp.

Mandatory standards include requirements for staff screening, emergency exits, first aid, aquatic-certified personnel, storage and use of flammables and firearms, emergency transportation, obtaining appropriate health information, among others.
www.ACAcamps.org/accreditation
**Other Standard** *(specify):*
Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.
-The member's medical issues, including allergies.
-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations outside the member's home or provider's place of business shall not exceed 72 continuous hours. If the respite setting is anywhere other than the member's home or the provider's place of business, for example a hotel, then respite provided in these locations are limited to 72 hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify):*

Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.
-The member's medical issues, including allergies.
-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency

**Provider Type:**
Nursing facilities and hospitals

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

Hospitals enrolled as providers in the Iowa Medicaid program as defined in IAC 441 77.3:
77.3(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program,subject to the additional requirements of this rule.

**Other Standard** *(specify):*
Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.
-The member's medical issues, including allergies.
-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.
Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency

**Provider Type:**
Adut Day Care Providers

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:
Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at IAC 481—Chapter 70:
"Accredited" means that the program has received accreditation from an accreditation entity recognized in Department of Inspections (DIA) rules for Adult Day Service: CARF or a recognized accrediting entity designated by the Department of Inspections and Appeals (DIA).
"Nonaccredited" means that the program has been certified under the provisions by DIA but has not received accreditation from the accreditation entity recognized by DIA
NonAccredited program Application content:
70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable: a. The real estate owner or lessor; b. The lessee; and c. The management company responsible for the day-to-day operation of the program.
70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.
70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.
70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.
70.4(5) The policy and procedure for service plans.
70.4(6) The policy and procedure for addressing medication needs of participants.
70.4(7) The policy and procedure for accidents and emergency response.
70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.
70.4(9) The policy and procedure for activities.
70.4(10) The policy and procedure for transportation.
70.4(11) The policy and procedure for staffing and training.
70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.
70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.
70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).
70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).
70.4(16) The participant contractual agreement and all attachments.
70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

70.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

**Other Standard** *(specify)*:

Respite providers shall meet the following conditions:

Providers shall maintain the following information that shall be updated at least annually:

-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

-An emergency medical care release.

-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.

-The member's medical issues, including allergies.

-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Verified based on the length of certifiction or license; recertification completed by the state done every 4 years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home Care Agencies

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Eligible Home care agencies are those that meet the conditions set forth in Iowa Administrative Code 441--77.33 (4).

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number. (at this time, the IDPH is no longer contracting for homemaker services.)

**Other Standard** *(specify)*:

Respite providers shall meet the following conditions:

Providers shall maintain the following information that shall be updated at least annually:

-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

-An emergency medical care release.

-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.

-The member's medical issues, including allergies.

-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:

-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Respite Providers Certified under the HCBS ID waiver

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Certified to provide respite by the Department's Home and Community Based Services Quality Oversight Unit as outlined in Iowa Administrative Code 441-77.37.5:

77.30(5) Respite care providers.
a. The following agencies may provide respite services:
(1) Home health agencies that are certified to participate in the Medicare program.
(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
(5) Camps certified by the American Camping Association.
(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
(9) Assisted living programs certified by the department of inspections and appeals.
**Other Standard** *(specify):*
Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:
-The member's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
-An emergency medical care release.
-Emergency contact telephone numbers such as the number of the member's physician and the spouse, guardian, or primary caregiver.
-The member's medical issues, including allergies.
-The member's daily schedule which includes the member's preferences in activities or foods or any other special concerns.
Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

Policies shall be developed for:
-Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.
-Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
-Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
-Ensuring the safety and privacy of the member. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Extended State Plan Service

**Service Title:**
Home Health Aide Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08020 home health aide |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Home health aide services are an extension of the State Plan and are personal or direct care services provided to the member, which are not payable under Medicaid as set forth in Iowa Administrative Code rule 441—78.9(249A). All state plan services must be accessed before seeking payment through the waiver. The scope and nature of waiver home health services do not differ from home health aid services furnished under the State plan. Services are defined in the same manner as provided in the approved State Plan. Skilled nursing care is not covered. The provider qualifications specified in the State plan apply.

Components of the waiver home health service include, but are not limited to:
(1) Observation and reporting of physical or emotional needs.
(2) Helping a member with bath, shampoo, or oral hygiene.
(3) Helping a member with toileting.
(4) Helping a member in and out of bed and with ambulation.
(5) Helping a member reestablish activities of daily living.
(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
(7) Performing incidental household services which are essential to the member's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

Home health services are provided under the Medicaid State Plan services until the limitations have been reached. Rehabilitation Act of 1973 must be accessed and/or exhausted first.

Overlapping of state plan and waiver services is avoided by the use of a case manager,CBCM or integrated health home care coordinator who manages all services.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is a visit. The member's plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan. The Case Manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- ( ) **Participant-directed as specified in Appendix E**
- (✓) **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Home Health Aide Services**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify):*
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training
(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based service.

The home health agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Extended State Plan Service
**Service Title:**
Nursing Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 05 Nursing | 05010 private duty nursing |

**Category 2:** 05 Nursing

**Sub-Category 2:** 05020 skilled nursing

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Nursing care services are an extension of the State Plan and are included in the plan of treatment approved by the physican and which are provided by licensed nurse to members in the home and community. The services shall be reasonable and necessary to the treatment of the illness or injury and include all nursing tasks recognized by the Iowa board of nursing.

Nursing services under the Medicaid state plan must be exhausted before nursing services are accessed under the waiver. Nursing Care Services under the state plan or waiver differ only in the duration of the services available under Medicaid state plan. Nursing care services under the waiver do not need to show an attempt to have a predictable end. The provider qualifications specified in the State plan apply.
Overlapping of services is avoided by the use of a case manager, CBCM, or integrated health home care coordinator who manages all services. Where there is a potential for overlap, services must first be exhausted under the Rehabilitation Act of 1973.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is a visit. The member's service plan will tell how the member's health care needs are being met. Services must be authorized in the service plan. The Case Manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Nursing Services**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify)*:
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training.
(3) Subject to background checks prior to direct service delivery.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**
Information and Assistance in Support of Participant Direction

**Alternate Service Title (if any):**
Financial Management Service

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12010 financial management services in support of self-directi |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and will be available only to those who self direct. The FMS will enroll as a Medicaid Provider. The FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

The FMS services are provided to ensure that the individualized budgets are managed and distributed according to the budget developed by each member and to facilitate the employment of service workers by members. The Iowa Department of Human Services will designate the Financial Management Service entities as Organized health care delivery system.

Responsibilities of the financial management service. The financial management service shall perform all of the following services:
(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
(6) Verify for the member an employee's citizenship or alien status.
(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate
(8) Assist the member in completing required federal, state, and local tax and insurance forms.
(9) Establish and manage documents and files for the member and the member's employees.
(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
(13) Establish a customer services complaint reporting system.
(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
(15) Develop a business continuity plan in the case of emergencies and natural disasters.
(16) Provide to the department an annual independent audit of the financial management service.
(17) Assist in implementing the state's quality management strategy related to the financial management service.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The upper limit for monthly payment may change periodically with legislatively approved provider rate increases. Provider rates are contained in Iowa Administrative Code Chapter 79.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Financial Institution |

| Provider Category | Provider Type Title |
|---|---|

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Financial Management Service**

**Provider Category:**
Agency
**Provider Type:**
Financial Institution
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
As defined in IAC 441 Chapter 77.30(13), the financial institution shall either:
(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
d. The financial institution shall enroll as a Medicaid provider.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Assisted Living

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 02 Round-the-Clock Services | 02013 group living, other |
| **Category 2:** | **Sub-Category 2:** |

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
The Assisted Living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting. The service includes the 24-hour on-site response capability to meet unpredictable resident needs as well as resident safety and security through incidental supervision. Examples of unanticipated and unscheduled resident needs include, but are not limited to: infrequent escort assistance, infrequent cutting of food, unexpected assistance with dressing or footwear, assistance with window closure during a storm, opening and closing window blinds, assistance with finding misplaced items, assistance with thermostat due to unexpected weather changes, cleanup of accidental messes, and retrieval of items from an individuals residence (sweater, blanket, etc.) due to unanticipated needs.
Personal care and supportive services provided are reimbursable as assisted living services when those services are determined non-duplicative of any other personal care and supportive services that have been authorized as medically necessary and implemented into the residents service plan by the residents case manager. The Assisted Living Service per diem rate is only payable when the provider has had at least one face to face contact with the member for that day. The provider will document the contact, including member response to the contact. Elderly Waiver Assisted Living Service is not reimbursable if performed at the same time as any service included in an approved CDAC agreement.
The case manager or integrated health home care coordinator will ensure that scheduled, anticipated, and routine needs (regular bathing, grooming, dressing, housecleaning, meal preparation/delivery, transportation, etc.) shall be provided by arranged personal care (CDAC) and supportive services (homemaker, chore, meals, transportation) as outlined in the residents service plan. The Assistive Living service shall not include scheduled or routine needs that should otherwise be provided by a personal care provider, supportive service provider or through a resident's private pay agreement. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not be made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

The case manager, CBCM, or integrated health home care coordinator is responsible to ensure that authorized Assisted Living services to not overlap other authorized waiver services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Rate is determined in agreement with the provider and member not to exceed the upper maximum specified in the Iowa Administrative Code. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day and documentation of at least one face to face encounter for that day.

**Service Delivery Method** *(check each that applies):*

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Assisted Living programs |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assisted Living**

**Provider Category:**
Agency

**Provider Type:**
Assisted Living programs

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
77.33(23) Assisted living on-call service. Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Assistive Devices

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

14 Equipment, Technology, and Modifications | 14031 equipment and technology

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Assistive devices are practical equipment products that assist members with activities of daily living and instrumental activities of daily living and allow the member more independence. Devices include, but not limited to: long reach brushs, extra long shoehorns, non-slip grippers to pick up and reach items, dressing aids, shampoo rinse trays and inflatable shampoo trays, double handed cups, and sipper lids.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is one item. The members' plan of care will address how the member's health needs are being met. The services must be authorized in the service plan. The Case Manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Assistive Device providers with AAA contract |
| Agency | Medical Equipment and Supply Dealers |
| Agency | Community Business |
| Agency | Area Agency on Aging |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Devices**

**Provider Category:**
Agency
**Provider Type:**
Assistive Device providers with AAA contract
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify):*

**Other Standard** *(specify):*
Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

17—6.11(231) Contracts and subgrants.
6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Devices**

**Provider Category:**
Agency

**Provider Type:**
Medical Equipment and Supply Dealers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Medicaid-enrolled medical equipment and supply dealers. 441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Devices**

**Provider Category:**
Agency
**Provider Type:**
Community Business
**Provider Qualifications**
**License** *(specify):*
Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Community businesses that are engaged in the provision of assistive devices and that Submit verification of current liability and workers' compensation coverage.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
every 4 years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Devices**

**Provider Category:**
Agency
**Provider Type:**
Area Agency on Aging
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government.Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:a.The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; andb.The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve.Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and

Iowa Code chapter 231. An area agency on aging shall be any one of the following:a.An established office of aging operating within a planning and service area;b.Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;c.Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose; d.Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; ore.Any other entity authorized by the Older Americans Act.4.4(8)Official designation.An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

every 4 years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Chore Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08060 chore |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:

Services needed to maintain the home as a clean, sanitary and safe enviroment. These services are proivided only when neither the member nor anyone else in the household is capable of performing and where no other relative, caregiver, landlord is capable or responsible for their provision. Chore services cannot be duplicative of any other waiver service.

Covered Chore services include the following services:
1. window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
2. minor repairs to walls, floors, stairs, railings and handles;
3. heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal;
4. mowing lawns, and removing snow and ice from sidewalks and driveways.

The following are not covered chore services:
1. leaf raking
2. bush and tree trimming
3. trash burning
4. stick removal
5. tree removal

The case manager, CBCM, or integrated health home care coordinator is responsible to ensure that the approved Chore service does not overlap with other approved waiver or similiar services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15 minutes. The member's service plan will allow the member's health needs to be met. Services must be authorized in the service plan. The Case manager, CBCM, or integrated health home care coordinator will monitor the care plan.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community Business |
| Agency | Area Agency on Aging Subcontractor |
| Agency | Community Action Agencies |
| Agency | Nursing Facilities |
| Agency | Home Health Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore Services**

**Provider Category:**
Agency
**Provider Type:**
Community Business
**Provider Qualifications**

**License** *(specify)*:
Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, including Iowa Code Chapter 490, and that submit verification of current liability and workers' compensation insurance.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Submit verification of current liability and workers' compensation coverage.

For this service the department does not have specific standards for subcontracts or providers regarding training,

age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCM, or IHH care coordinators, are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore Services**

**Provider Category:**

Agency

**Provider Type:**

Area Agency on Aging Subcontractor

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an Area Agency on Aging. IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.
17—6.11(231) Contracts and subgrants.

6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

Submit verification of current liability and workers` compensation coverage.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore Services**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Submit verification of current liability and workers' compensation coverage.

Community action agencies as designated in Iowa Code section 216A.93.
216A.92 Division of community action agencies.
1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore Services**

**Provider Category:**
Agency
**Provider Type:**
Nursing Facilities
**Provider Qualifications**
**License** *(specify):*
Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Submit verification of current liability and workers' compensation coverage.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore Services**

**Provider Category:**
Agency

**Provider Type:**
Home Health Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify):*
Submit verification of current liability and workers' compensation coverage.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Consumer Directed Attendant Care-unskilled

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08030 personal care |
| **Category 2:** | **Sub-Category 2:** |

08 Home-Based Services | 08050 homemaker

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. This service may be provided in the private residence or assisted living. This service is not duplicative of Home Health Aide or Homemaker services; and is monitored by the case manager, CBCM, or integrated health home care coordinator as part of inclusion in the member's plan. The service activities may include helping the member with any of the following non-skilled service activities:
1) Dressing.
2) Bath, shampoo, hygiene, and grooming.
3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4) Toilet assistance, including bowel, bladder, and catheter assistance.
5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
6) Housekeeping services which are essential to the member's health care at home, includes shopping and laundry.
7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider.
8) Wound care.
9) Assistance needed to go to or return from a place of employment and assistance with job related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in member directed attendant care services.
10) Tasks such as financial management and scheduling that require cognitive or physical assistance.
11) Communication essential to the health and welfsre of the member, through interpreting and reading sevices and use of assistive devises for communication.
(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15-minutes. The member's plan of care will address how the member's health care needs are being met. The case manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- ( ) **Participant-directed as specified in Appendix E**
- (✓) **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- (✓) **Legally Responsible Person**
- (✓) **Relative**
- (✓) **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | AAA subtracting Chore Providers |
| Agency | Community Action Agency |
| Agency | Home Health Agency |
| Agency | Assisted Living Programs |
| Agency | Supported Community Living Providers |
| Agency | Adult Day Care |
| Agency | Home Care Provider |
| Individual | Any individual who contracts with the member |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Agency
**Provider Type:**
AAA subtracting Chore Providers
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an Area Agency on Aging. IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.
17—6.11(231) Contracts and subgrants.

6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCM, IHH care coordinators, are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

Community action agencies as designated in Iowa Code section 216A.93.

216A.92 Division of community action agencies.

1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.

2. The division shall do all of the following:

a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.

b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.

c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.

d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCM, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Agency
**Provider Type:**
Assisted Living Programs
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Assisted Living programs certified by the Department of Inspections and Appeals as defined in IAC 481 Chapter 69.2.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.
For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Agency
**Provider Type:**
Supported Community Living Providers
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37(14) and 77.39(14).

77.37(14) Supported community living providers.
a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.
b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.
c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.
d. All supported community living providers shall meet the following requirements:
(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification.
These timelines shall include:
1. Implementation of necessary staff training and consumer input.
2. Implementation of providersystem changesto allow for flexibility in staff duties,services based on what each individual needs, and removal of housing as part of the service.
(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.
e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
f. The departmentshall approve a living unit designed to serve five personsif both of the following conditions are met:
(1) Approval will not result in an overconcentration of supported community living units in a geographic area.
(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(13) Supported community living providers.
a. The departmentshall certify only public or private agenciesto provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.
b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.
c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.
d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.
(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.
e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
f. The departmentshall approve a living unit designed to serve five personsif both of the following conditions are met:
(1) Approval will not result in an overconcentration of supported community living units in a geographic area.
(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Agency

**Provider Type:**
Adult Day Care

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:
Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70: "Accredited" means that the program has received accreditation from an accreditation entity recognized in Department of Inspections (DIA) rules for Adult Day Service: CARF or a recognized accrediting entity designated by the Department of Inspections and Appeals (DIA).
"Nonaccredited" means that the program has been certified under the provisions by DIA but has not received accreditation from the accreditation entity recognized by DIA
NonAccredited program Application content:
70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable: a. The real estate owner or lessor; b. The lessee; and c. The management company responsible for the day-to-day operation of the program.
70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.
70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.
70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.
70.4(5) The policy and procedure for service plans.
70.4(6) The policy and procedure for addressing medication needs of participants.
70.4(7) The policy and procedure for accidents and emergency response.
70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.
70.4(9) The policy and procedure for activities.
70.4(10) The policy and procedure for transportation.
70.4(11) The policy and procedure for staffing and training.
70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.
70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.
70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).
70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).
70.4(16) The participant contractual agreement and all attachments.
70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

70.4(18) A copy of the state license for the entity that provides food service. whether the entity is the program or an outside entity or a combination of both.

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**

Agency

**Provider Type:**

Home Care Provider

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641—80.3(5), 641—80.3(6), and 641—80.3(7):

80.3(5) Coordination of home care aide services.
a. The authorized agency is responsible for determining the ability of a job applicant to meet the requirements outlined in the job description. At a minimum, individuals performing coordination of home care aide services shall meet one of the following criteria:
(1) Be a registered nurse (RN) licensed to practice nursing in the state of Iowa; or
(2) Possess a bachelor's degree in social work, sociology, family and consumer science, education, or other health or human services field; or
(3) Be a licensed practical nurse (LPN) licensed to practice nursing in the state of Iowa; or
(4) Be an individual with two years of related public health experience.
b. Individuals who are responsible for the coordination of home care aide services on or before June 30, 2015, are exempt from the criteria in paragraph 80.3(5)"a."

80.3(6) Home care aide services.
a. The authorized agency shall ensure that each individual assigned to perform home care aide services meets one of the following:
(1) Be an individual who has completed orientation to home care in accordance with agency policy. At a minimum, orientation shall include four hours on the role of the home care aide; two hours on communication; two hours on understanding basic human needs; two hours on maintaining a healthy environment; two hours on infection control in the home; and one hour on emergency procedures. The individual shall have successfully passed an agency written test and demonstrated the ability to perform skills for the assigned tasks; or
(2) Be an individual who is in the process of receiving education or has completed the educational requirements but is not licensed as an LPN or RN, has documentation of successful completion of coursework related to the tasks to be assigned, and has demonstrated the ability to perform the skills for the assigned tasks; or
(3) Be an individual who possesses a license to practice nursing as an LPN or RN in the state of Iowa; or
(4) Be an individual who is in the process of receiving education or who possesses a degree in social work, sociology, family and consumer science, education, or other health and human services field; has documentation of successful completion of coursework related to the tasks to be assigned; and has demonstrated the ability to perform the skills for the assigned tasks.
b. The authorized agency shall ensure that services or tasks assigned are appropriate to the individual's prior education and training.
c. The authorized agency shall ensure documentation of each home care aide's completion of at least 12 hours of annual in-service (prorated to employment).
d. The authorized agency shall establish policies for supervision of home care aides.

e. The authorized agency shall maintain records for each consumer. The records shall include:
(1) An initial assessment;
(2) A plan of care;
(3) Assignment of home care aide;
(4) Assignment of tasks;
(5) Reassessment;
(6) An update of the plan of care;
(7) Home care aide documentation; and
(8) Documentation of supervision of home care aides.

80.3(7) Coordination of case management services.
a. The authorized agency is responsible for determining the ability of a job applicant to meet the requirements outlined in the job description. At a minimum, individuals responsible for coordinating case management services shall meet one of the following criteria:
(1) Be a registered nurse (RN) licensed to practice nursing in the state of Iowa; or
(2) Possess a bachelor's degree with at least one year of experience in the delivery of services to vulnerable populations; or
(3) Be a licensed practical nurse (LPN) licensed to practice nursing in the state of Iowa.
b. A home care aide with an equivalent of two years' experience may be delegated coordination of case management services as long as a qualified individual who meets one of the criteria in paragraph 80.3 (7)"a" retains responsibility and provides supervision.
c. Individuals who are responsible for the coordination of case management services on or before June 30, 2015, are exempt from the criteria in paragraph 80.3(7)"a."
d. Case management services shall be provided at the direction of the consumer. The documentation to support the case management services shall include at a minimum:
(1) An initial assessment of the consumer's needs;
(2) Development and implementation of a service plan to meet the identified needs;
(3) Linking of the consumer to appropriate resources and natural supports; and
(4) Reassessment and updating of the consumer's service plan at least annually.

**Other Standard** *(specify)*:

Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the case manager, CBCMs, and IHH care coordinators shall oversee service provision.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer Directed Attendant Care-unskilled**

**Provider Category:**
Individual

**Provider Type:**
Any individual who contracts with the member

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Consumer-directed attendant care - Skilled

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Consumer Directed Attendant Care skilled activities may include helping the member with any of the following skilled services while under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. This service may be provided in the private residence or assisted living. Skilled CDAC is not skilled nursing care, but is care provided by a lay person who has been trained to provide the specific service needed by the member.

The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The nurse is responsible for overseeing the care of the Medicaid member but is not the service provider. The cost of the supervision provided under state plan funding and is not provided under the waiver.

Skilled CDAC service is not duplicative of HHA or nursing. The case manager, CBCM, or integrated health home care coordinator through the service plan authorization specifies the services and providers to provide waiver services and precludes duplication of services.

Covered skilled serice activities:
(1) Tube feedings of members unable to eat solid foods.
(2) Intravenous therapy administered by a registered nurse.
(3) Parenteral injections required more than once a week.
(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation,and behavior modification.
(8) Colostomy care.
(9) Care of out of control medical conditions which includes brittle diabetes, and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15-minutes provided by an individual or an agency. The member's plan of care will address how the member's health care needs are being met. The case manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Supported Community Living Providers |
| Agency | Home Care Providers |
| Agency | Community action agency |
| Agency | Home Health Agencies |
| Agency | Assisted Living program |
| Agency | Adult Day CArc provider |
| Agency | AAA subcontracting Chore Providers |
| Individual | any individual who contracts with the member |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency
**Provider Type:**
Supported Community Living Providers
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37(14) and 77.39(14).

77.37(14) Supported community living providers.
a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.
b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.
c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.
d. All supported community living providers shall meet the following requirements:
(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification.
These timelines shall include:
1. Implementation of necessary staff training and consumer input.
2. Implementation of providersystem changesto allow for flexibility in staff duties,services based on what each individual needs, and removal of housing as part of the service.
(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.
e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
f. The departmentshall approve a living unit designed to serve five personsif both of the following conditions are met:
(1) Approval will not result in an overconcentration of supported community living units in a geographic area.
(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(13) Supported community living providers.

a. The departmentshall certify only public or private agenciesto provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.
b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.
c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.
d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.
(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.
e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
f. The departmentshall approve a living unit designed to serve five personsif both of the following conditions are met:
(1) Approval will not result in an overconcentration of supported community living units in a geographic area.
(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Service, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency

**Provider Type:**
Home Care Providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in Iowa Administrative Code 641—80.3(5), 641—80.3(6), and 641—80.3(7):

80.3(5) Coordination of home care aide services.
a. The authorized agency is responsible for determining the ability of a job applicant to meet the requirements outlined in the job description. At a minimum, individuals performing coordination of home care aide services shall meet one of the following criteria:
(1) Be a registered nurse (RN) licensed to practice nursing in the state of Iowa; or
(2) Possess a bachelor's degree in social work, sociology, family and consumer science, education, or other health or human services field; or
(3) Be a licensed practical nurse (LPN) licensed to practice nursing in the state of Iowa; or
(4) Be an individual with two years of related public health experience.
b. Individuals who are responsible for the coordination of home care aide services on or before June 30, 2015, are exempt from the criteria in paragraph 80.3(5)"a."

80.3(6) Home care aide services.
a. The authorized agency shall ensure that each individual assigned to perform home care aide

services meets one of the following:
(1) Be an individual who has completed orientation to home care in accordance with agency policy. At a minimum, orientation shall include four hours on the role of the home care aide; two hours on communication; two hours on understanding basic human needs; two hours on maintaining a healthy environment; two hours on infection control in the home; and one hour on emergency procedures. The individual shall have successfully passed an agency written test and demonstrated the ability to perform skills for the assigned tasks; or
(2) Be an individual who is in the process of receiving education or has completed the educational requirements but is not licensed as an LPN or RN, has documentation of successful completion of coursework related to the tasks to be assigned, and has demonstrated the ability to perform the skills for the assigned tasks; or
(3) Be an individual who possesses a license to practice nursing as an LPN or RN in the state of Iowa; or
(4) Be an individual who is in the process of receiving education or who possesses a degree in social work, sociology, family and consumer science, education, or other health and human services field; has documentation of successful completion of coursework related to the tasks to be assigned; and has demonstrated the ability to perform the skills for the assigned tasks.
b. The authorized agency shall ensure that services or tasks assigned are appropriate to the individual's prior education and training.
c. The authorized agency shall ensure documentation of each home care aide's completion of at least 12 hours of annual in-service (prorated to employment).
d. The authorized agency shall establish policies for supervision of home care aides.
e. The authorized agency shall maintain records for each consumer. The records shall include:
(1) An initial assessment;
(2) A plan of care;
(3) Assignment of home care aide;
(4) Assignment of tasks;
(5) Reassessment;
(6) An update of the plan of care;
(7) Home care aide documentation; and
(8) Documentation of supervision of home care aides.

80.3(7) Coordination of case management services.
a. The authorized agency is responsible for determining the ability of a job applicant to meet the requirements outlined in the job description. At a minimum, individuals responsible for coordinating case management services shall meet one of the following criteria:
(1) Be a registered nurse (RN) licensed to practice nursing in the state of Iowa; or
(2) Possess a bachelor's degree with at least one year of experience in the delivery of services to vulnerable populations; or
(3) Be a licensed practical nurse (LPN) licensed to practice nursing in the state of Iowa.
b. A home care aide with an equivalent of two years' experience may be delegated coordination of case management services as long as a qualified individual who meets one of the criteria in paragraph 80.3(7)"a" retains responsibility and provides supervision.
c. Individuals who are responsible for the coordination of case management services on or before June 30, 2015, are exempt from the criteria in paragraph 80.3(7)"a."
d. Case management services shall be provided at the direction of the consumer. The documentation to support the case management services shall include at a minimum:
(1) An initial assessment of the consumer's needs;
(2) Development and implementation of a service plan to meet the identified needs;
(3) Linking of the consumer to appropriate resources and natural supports; and
(4) Reassessment and updating of the consumer's service plan at least annually.
**Other Standard** *(specify):*
Providers must be:
1. At least 18 years of age.
2. Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

The home care agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the case managers, CBCMs, and IHH care coordinators shall oversee service provision.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**

Agency

**Provider Type:**

Community action agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

Community action agencies as designated in Iowa Code section 216A.93.

216A.92 Division of community action agencies.

1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.

2. The division shall do all of the following:

a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.

b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.

c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.

d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
**Other Standard** *(specify)*:

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency
**Provider Type:**
Assisted Living program
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Assisted living programs that are certified by the Iowa department of inspections and appeals under 481—Chapter 69.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the

publications are released.
For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The Iowa Department of Human Services, the Iowa Medicaid Enterprise
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency
**Provider Type:**
Adult Day CAre provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70:.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in Department of Inspections (DIA) rules for Adult Day Service: CARF or a recognized accrediting entity designated by the Department of Inspections and Appeals (DIA).
"Nonaccredited" means that the program has been certified under the provisions by DIA but has not received accreditation from the accreditation entity recognized by DIA
NonAccredited program Application content:
70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable: a. The real estate owner or lessor; b. The lessee; and c. The management company responsible for the day-to-day operation of the program.
70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.
70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.
70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.
70.4(5) The policy and procedure for service plans.
70.4(6) The policy and procedure for addressing medication needs of participants.
70.4(7) The policy and procedure for accidents and emergency response.
70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.
70.4(9) The policy and procedure for activities.
70.4(10) The policy and procedure for transportation.
70.4(11) The policy and procedure for staffing and training.
70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as

applicable.
70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.
70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).
70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).
70.4(16) The participant contractual agreement and all attachments.
70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.
70.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The Iowa Department of Human Services, the Iowa Medicaid Enterprise

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**
Agency

**Provider Type:**
AAA subcontracting Chore Providers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an Area Agency on Aging. IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.
17—6.11(231) Contracts and subgrants.

6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit

organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Consumer-directed attendant care - Skilled**

**Provider Category:**

Individual

**Provider Type:**

any individual who contracts with the member

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

An individual who contracts with the member to provide attendant care service and who is:

1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Home and Vehicle Modification

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services. Home and vehicle repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle is not allowable.
b. Only the following modifications are covered:
(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
(3) Grab bars and handrails.
(4) Turnaround space adaptations.
(5) Ramps, lifts, and door, hall and window widening.
(6) Fire safety alarm equipment specific for disability.
(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
(9) Keyless entry systems.
(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes. Services shall be performed following prior department approval of the modification as specified in 441-subrule 79.1 (17) and a binding contract between the provider and the member. All contracts for home or vehicle modification shall be awarded through competive bidding.

Home modifications will not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, including an assisted living facility.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is the completion of needed modifications or adaptations. There is a life time limit of services for this service; the limit is contained in the Iowa Administrative Code. If the member's needs exceeds the lifetime limit, then an exception to policy (ETP)can be submitted for evaluation. The Director of the Department of Human Services determines whether or not the exception will be granted. The member's plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan by the case manager, CBCMs, or integrated health home care coordinator.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Community Action Agency |
| Agency | Area Agencies on Aging |
| Agency | HVM Providers under other waivers |
| Agency | Community Business |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home and Vehicle Modification**

**Provider Category:**
Individual
**Provider Type:**
Community Action Agency
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Iowa Code 216A.93 Establishment of community action agencies. The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements.

Submit verification of current liability and workers' compensation coverage.

Community action agencies as designated in Iowa Code section 216A.93.
216A.92 Division of community action agencies.
1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every 4 years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home and Vehicle Modification**

**Provider Category:**
Agency
**Provider Type:**
Area Agencies on Aging
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Area agencies on aging as designated according to department on aging rules IAC17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation.The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:a.The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; andb.The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve.Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:a.An established office of aging operating within a planning and service area;b.Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;c.Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such

purpose; d.Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; ore.Any other entity authorized by the Older Americans Act.4.4(8)Official designation.An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home and Vehicle Modification**

**Provider Category:**

Agency

**Provider Type:**

HVM Providers under other waivers

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

Providers enrolled to participate as HVM providers under the Health and Disability Waiver (formerly the Ill and Handicapped waiver) as described in IAC 441 Chapter 30:
a.Area agencies on aging as designated in 17—4.4(231).
b.Community action agencies as designated in Iowa Code section 216A.93.
c.Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
d.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

Enrolled as HVM providers under the Physical Disability Waiver as described in IAC 441 41:
a.Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
b.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

Enrolled to provide HVM services under the Intellectual Disabiltiy described in IAC 441 Chapter 37:
a.Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.
b.Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.
c.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

Enrolled to provide HVM services under the Brain Injury Waiver as described in IAC 441 Chapter 39:
a.Providers eligible to participate as home and vehicle modification providers under the elderly or health and

disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.
b.Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home and Vehicle Modification**

**Provider Category:**
Agency

**Provider Type:**
Community Business

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
77.33(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:
d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Home Delivered Meals

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 06 Home Delivered Meals | 06010 home delivered meals |

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Home delivered meals are meals prepared elsewhere and delivered to a waiver member's residence. Each meal shall ensure the member receives a minimum of one third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National of the National Research Council of the National Academy of Sciences. The meal may be a liquid supplement which meets the minimum one third standard.

When a restaurant provides the home delivered meal, the member is required to have nutritional consulation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and explain that constitutes the minimum one third daily dietary allowance.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A maximum of 14 meals is allowed per week. A unit of service is a meal. The members' plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan. The case manager, CBCM, or integrated health home care coordinator will monitor the plan.

Services will be monitored by the case manager, CBCM, or integrated health home care coordinator through the service plan to avoid duplication with other services such as with homemaker and consumer-directed attendant care. While homemaker and CDAC may cover meal prep and clean up; home delivered meals covers the cost of food which is not covered under any other waiver service.

**Service Delivery Method** *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |
| Agency | Nursing Facilities |
| Agency | Community Action Agencies |
| Agency | Area Agencies on Aging |
| Agency | Medical Equipment and Supply Dealers |
| Agency | Home Care Agencies |
| Agency | Assisted Living Facilities |
| Agency | Subcontractor with Area Agencies on Aging |
| Agency | Hospitals |
| Agency | Restaurants |

## Appendix C: Participant Services

## C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Home Health Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.
**Other Standard** *(specify):*
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

# Appendix C: Participant Services

## C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Nursing Facilities
**Provider Qualifications**
**License** *(specify):*
Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in IAC 441 Chapter 81.

Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Community action agencies as designated in Iowa Code section 216A.93.
216A.92 Division of community action agencies.
1. The division of community action agencies is established. The purpose of the division of community action agencies is to strengthen, supplement, and coordinate efforts to develop the full potential of each citizen by recognizing certain community action agencies and supporting certain community-based programs delivered by community action agencies.
2. The division shall do all of the following:
a. Provide financial assistance for community action agencies to implement community action programs, as permitted by the community service block grant and subject to the funding made available for the program.
b. Administer the community services block grant, the low-income energy assistance block grants, department of energy funds for weatherization, and other possible funding sources. If a political subdivision is the community action agency, the financial assistance shall be allocated to the political subdivision.
c. Implement accountability measures for its programs and require regular reporting on the measures by the community action agencies.
d. Issue an annual report to the governor and general assembly by July 1 of each year.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Area Agencies on Aging
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Area agencies on aging as designated according to department on aging rules IAC17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if: a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following: a. An established office of aging operating within a planning and service area; b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit; c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose; d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or e. Any other entity authorized by the Older Americans Act.4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency

**Provider Type:**
Medical Equipment and Supply Dealers

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify):*
Medical equipment and supply dealer certified to participate in the Medicaid program as defined by IAC 441 Chapter 77.10: All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**Other Standard** *(specify):*
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency

**Provider Type:**
Home Care Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Home care providers meeting the standards set forth in subrule 77.33(4):
a.Certified as a home health agency under Medicare, or
b.Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**Other Standard** *(specify):*
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency

**Provider Type:**
Assisted Living Facilities

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Assisted living programs that are certified by the Iowa department of inspections and appeals under 481—Chapter 69.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.
**Other Standard** *(specify):*
For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education than what would be contained in IAC 481-chapter 69. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency

**Provider Type:**
Subcontractor with Area Agencies on Aging

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide home-delivered meals services.
Area agencies on aging as designated according to department on aging rules IAC17—4.4(231)

IAC 17—4.4(231)Area agencies on aging.
4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation

requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if: a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following: a. An established office of aging operating within a planning and service area; b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit; c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose; d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or e. Any other entity authorized by the Older Americans Act.4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.
6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**
Hospitals
**Provider Qualifications**
**License** *(specify)*:
Enrolled as a Medicaid Provider as described in IAC 441 Chapter 77.3: All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.
**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Delivered Meals**

**Provider Category:**
Agency
**Provider Type:**
Restaurants
**Provider Qualifications**
**License** *(specify)*:
Licensed and inspected under Iowa Code Chapter 137F:
137F.3 Authority to enforce.
1. The director shall regulate, license, and inspect food establishments and food processing plants and enforce this chapter pursuant to rules adopted by the department in accordance with chapter 17A. Municipal corporations shall not regulate, license, inspect, or collect license fees from food establishments and food processing plants, except as provided in this section.

137F.4 License required.
A person shall not operate a food establishment or food processing plant to provide goods or services to the general public, or open a food establishment to the general public, until the appropriate license has been obtained from the regulatory authority. Sale of products at wholesale to outlets not owned by a commissary owner requires a food processing plant license. A license shall expire one year from the date of issue. A license is renewable. All licenses issued under this chapter that are not renewed by the licensee on or before the expiration date shall be subject to a penalty of ten percent per month of the license fee if the license is renewed at a later date.

137F.10 Regular inspections.
The appropriate regulatory authority shall provide for the inspection of each food establishment and food processing plant in this state in accordance with this chapter and with rules adopted pursuant to this chapter in accordance with chapter 17A. A regulatory authority may enter a food establishment or food processing plant at any reasonable hour to conduct an inspection. The manager or person in charge of the food establishment or food processing plant shall afford free access to every part of the premises and render all aid and assistance necessary to enable the regulatory authority to make a thorough and complete inspection. As part of the inspection process, the regulatory authority shall provide an explanation of the violation or violations cited and provide guidance as to actions for correction and elimination of the violation or violations.
**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Food service establishments are places that prepare food for individual portion service and include catering operations. Both retail food establishments and food service establishments are regulated under the 1997 FDA

Food Code. The purpose of the Food Code is to safeguard the public health and provide food to consumers that is safe, unadulterated, and honestly presented.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Independant Support Brokerage Service

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Independent Support Brokerage service is necessary for all members who chose the self-direction option. This is a service that is included in the member's Budget. The Independent Support Brokerage will be chosen and hired by the member. The ISB will work with the member to guide them through the person centered planning process and offer technical assistance and expertise for selecting and hiring employees and/or providers and purchasing supports.

The independent support broker shall perform the following services as directed by the member or the member's representative:
(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
(3) Complete the required employment packet with the financial management service.
(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
(7) Assist the member with negotiating with entities providing services and supports if requested by the member.
(8) Assist the member with contracts and payment methods for services and supports if requested by the member.
(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
This service is necessary for members who choose the self-direction option at a maximum of 26 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly for the first three months and quarterly after that. If a member needs additional support brokerage service, the member will need prior authorization from the state.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Support Broker |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Independant Support Brokerage Service**

**Provider Category:**
Individual
**Provider Type:**
Independent Support Broker
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications:
a. The broker must be at least 18 years of age.
b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
c. The broker shall not provide any other paid service to the member.
d. The broker shall not work for an individual or entity that is providing services to the member.
e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
f. The broker must complete independent support brokerage training approved by the department

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Financial Management System Provider and Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise. The Independent Support Broker will be responsible for attending one support broker training a year.

Verification of qualifications occurs every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Individual Directed Goods and Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:
1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

Members (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Members or their guardians must review all time cards to ensure accuracy and work with their case manager or integrated health home care coordinator, and ISB to budget services. If a member is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

The case manager, CBCM, or integrated health home care coordinator is responsible to ensure that provision of Individual Directed Good and Services does not overlap with other service provision.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount.

The followiong goods an services may not be purchased using a self-directed budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individuals or businesses |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Individual Directed Goods and Services**

**Provider Category:**

Individual

**Provider Type:**
Individuals or businesses
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have current liability and workers' compensation coverage.

All personnel providing individual-directed goods and services shall:
(1) Be at least 18 years of age.
(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.
d. The provider of individual-directed goods and services shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.
(3) Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The member, the independent support broker and the financial management service.
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Mental Health Outreach

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 10 Other Mental Health and Behavioral Services | 10010 mental health assessment |
| **Category 2:** | **Sub-Category 2:** |
| 10 Other Mental Health and Behavioral Services | 10060 counseling |
| **Category 3:** | **Sub-Category 3:** |

Category 4: Sub-Category 4:

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Mental Health Outreach services are services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. These services can only be provided on the basis of a referral from the interdisciplinary team.

The mental health outreach provider developes a written assessment for each member served. This assessment is the basis for the services provided to the member. Staff base decisions regarding the level, type and immediacy of services to be provided, or the need for further assessment, upon the analysis of the information gathered in the assessment.

The individualized services emphasize mental health treatment and intensive psychosocial rehabilitation with activities designed to increase the member's abiltiy to function independently. Individual and group treatmentand rehabilitation services are based on the indivudual needs and identified mental health issues.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of services is 15 minutes. Because Iowa's state plan for mental health and substance abuse now serves Medicaid members over the age of 64, services to be provided under Mental Health Outreach would be very limited. The case manager, CBCM, or integrated health home care coordinator is responsible to ensure the member is fully accessing the State Plan before any Mental Health Outreach services are authorized.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Mental Heatlh Services provider |
| Agency | Community Mental Health Centers |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Mental Health Outreach**

**Provider Category:**
Agency
**Provider Type:**
Mental Heatlh Services provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Accredited by the Division of Mental Health and Disability Services as described in IAC 441 Chapter 24:
Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:

1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).
2. Those that may contract with a county board of supervisors for special services to the general public orspecialsegments of the general public and that are not accredited by any other accrediting body. These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Mental Health Outreach**

**Provider Category:**
Agency

**Provider Type:**
Community Mental Health Centers

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
"Community mental health center" means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A.

230A.1 ESTABLISHMENT AND SUPPORT OF COMMUNITY MENTAL HEALTH CENTERS.

A county or affiliated counties, by action of the board or boards of supervisors, with approval of the administrator of the division of mental health and disability services of the department of human services, may establish a community mental health center under this chapter to serve the county or counties. This section does not limit the authority of the board or boards of supervisors of any county or group of counties to continue to expend money to support operation of the center, and to form agreements with the board of supervisors of any additional county for that county to join in supporting and receiving services from or through the center.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Nutritional Counseling

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11040 nutrition consultation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:

Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. Standard medical management practices can diagnose the need for nutritional counseling, but may not be equiped by either staff or training to provide the long term, high intensity service provided by a nutritional counselor. Nutritional counseling can be medically necessary for chronic disease management as well as when a member is experiencing problematic weight gain or loss. Members experiencing eating disorders or chemical dependencies, taking certain prescription drugs (IE treating depression or anxiety), and with dietary restrictions benefit from the additional education and experience available with a nutritional counselor.

Nutritional counseling service must be face to face contact and specified in the service plan based on recommendations from a licensed dietician.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A unit of services is 15 minutes. The member's service plan will show if the member's health care needs are being met. The service must be authorized in the service plan and the case manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| | |

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home Health Agencies |
| Agency | Hospitals |
| Agency | Community Action Agencies |
| Individual | Licensed Dietitians |
| Agency | Nursing Facilites |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Agency

**Provider Type:**
Home Health Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that an HHA must meet in order to participate in Medicare.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Agency

**Provider Type:**
Hospitals

**Provider Qualifications**

**License** *(specify):*
Hospitals enrolled as providers in the Iowa Medicaid program as defined in IAC 441 77.3:
77.3(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program,subject to the additional requirements of this rule.

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agencies
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Iowa Code 216A.93 Establishment of community action agencies. The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements
**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Individual
**Provider Type:**
Licensed Dietitians
**Provider Qualifications**
**License** *(specify):*
Independent licensed dietitians under IAC 645—Chapter 81.

645—81.4(152A) Requirements for licensure. The following criteria shall apply to licensure:
81.4(1) The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the board office. All applications shall be sent to Board of Dietetics, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.
81.4(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.
81.4(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Dietetics. The fees are nonrefundable.
81.4(4) No application will be considered by the board until:
a. Official copies of academic transcripts have been sent directly from the school to the board;

b. Official verification statements have been sent to the board from the didactic and internship or preprofessional practice programs or from the Commission on Dietetic Registration (CDR) to verify completion of the academic and preprofessional practice requirements; and
c. The applicant satisfactorily completes the registration examination for dietitians administered by the Commission on Dietetic Registration (CDR). The board will accept the passing score set by CDR. Verification of satisfactory completion may be established by one of the following:
(1) The applicant sends to the board a notarized copy of the CDR registration card;
(2) CDR sends an official letter directly to the board to verify that the applicant holds registration status; or
(3) CDR posts Web-based verification that the applicant holds registration status.

645—81.7(152A) Licensure by endorsement. An applicant who has been a licensed dietitian under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:
1. Submits to the board a completed application;
2. Pays the licensure fee;
3. Shows evidence of licensure requirements that are similar to those required in Iowa;
4. Provides official copies of the academic transcripts;
5. Provides a notarized copy of the Commission on Dietetic Registration (CDR) registration card or an alternate form of verification of passing the registration examination, as stated in 81.4(4)"c"; and
6. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:
- Licensee's name;
- Date of initial licensure;
- Current licensure status; and
- Any disciplinary action taken against the license.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Agency

**Provider Type:**
Nursing Facilites

**Provider Qualifications**

**License** *(specify)*:
Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Personal Emergency Response or Portable Locator System

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:
1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability. The required components of the portable locator system are:
1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

Provider staff are responsible for training members regarding the use of the system; the cost of this service is included in the

charges for installation or monthly fee, depending upon how the provider structures their fee schedule. If necessary, case managers, CBCM, or integrated health home care coordinator would also assist members in understanding how to utilize the system.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is a one time installation fee or month of service. Maximum units per state fiscal year shall be one intital installation and 12 months of service. The member's plan of care will address how the member's health care needs are met. Services must be authorized in the service plan. The Case Manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Emergency Response Agency |
| Agency | Assisted Living Facility |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Emergency Response or Portable Locator System**

**Provider Category:**
Agency
**Provider Type:**
Emergency Response Agency
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Emergency response system providers must meet the following standards:
a. The agency shall provide an electronic component to transmit a coded signal via digital equipment to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.
b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.
c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.
e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Emergency Response or Portable Locator System**

**Provider Category:**
Agency
**Provider Type:**
Assisted LIving Facility
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Assisted Living programs certified by the Department of Inspections and Appeals as defined in IAC 481 Chapter 69.2.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.
"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).
"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).
481—69.14(231C) Recognized accrediting entity.
69.14(1) The department designates CARF as a recognized accrediting entity for programs.
69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.
69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.
69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.
**Other Standard** *(specify)*:
Emergency response system providers must meet the following standards:
a. The agency shall provide an electronic component to transmit a coded signal via digital equipment to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.
b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.
c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.
d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.
e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Self Directed Community Support and Employment

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Supported Employment-Individual Employment Support services are the ongoing support to members who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The outcome of the this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.
Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self- employment. Supported employment services are individualized and may include any combination of the following services: vocational/job –related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching , benefits and work-incentives planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Documentation is maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA ( 20 U.S.C. 1401 et seq.)

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Self-directed community supports and employment are services must be identified in the member's service plan developed by

the member's case manager, CBCM, or integrated health home care coordinator. Transportation may be covered for members from their place of residence and the employment site as a component of this service and the cost may be included in the rate. The following are examples of supports a member can purchase to help the member live and work in the community:

- Career counseling
- Career preparation skills development
- Cleaning skills development
- Cooking skills development
- Grooming skills development
- Job hunting and career placement
- Personal and home skills development
- Safety and emergency preparedness skills development
- Self-direction and self-advocacy skills development
- Social skills development training
- Supports to attend social activities
- Supports to maintain a job
- Time and money management
- Training on use of medical equipment
- Utilization of public transportation skills development
- Work place personal assistance

Members(or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Members or their guardians must review all time cards to ensure accuracy and work with their case manager, CBCM, or integrated health home care coordinator, and ISB to budget services. If a member is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The elderly waiver allows for the following waiver services to be converted to create a CCO budget:

1. Consumer-directed attendant care (unskilled).
2. Assistive devices
3. Home and vehicle modification.
4. Chore Service
5. Basic individual respite care.
6. Home delivered meals
7. Homemaker service
8. Transportation
9. Senior companion

A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual or business |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Self Directed Community Support and Employment**

**Provider Category:**
Individual

**Provider Type:**

Individual or business

**Provider Qualifications**

**License** *(specify)*:

A business providing community supports and employment shall:
(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and
(2)Have current liability and workers' compensation coverage as required by law.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements:
• All personnel providing individual-directed community supports and employment shall:
(1) Be at least 18 years of age.

•(2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

The provider of individual-directed community supports and employment shall:
(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
(2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

member, the independent support broker and the financial management service

**Frequency of Verification:**

Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Self-directed Personal Care

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remainin the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to promt the member to perform a task. Personal care may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.

These services are only available for those that self-direct. The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager. CBCM, or integrated health home care coordinator who manages all services. The case manager, CBCM, or integrated health home care coordinator. and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self -directed services.

Members (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Members or their guardians must review all time cards to ensure accuracy and work with their case manager or integrated health home care coordinator, and ISB to budget services. If a member is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Self directed personal care services need to be identified on the individual budget plan. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjusument rate will be applied to the individual budget amount. Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

**Service Delivery Method** *(check each that applies):*

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Individual or business |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Self-directed Personal Care**

**Provider Category:**
Agency
**Provider Type:**
Individual or business
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations. The consumer and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budget

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The member, the Independent support broker and the financial management service

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Senior Companion

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08040 companion |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*
Senior Companion are non-medical care supervision, oversight, and respite. Companion may assist with such tasks as meal preparations, laundry, shopping and light housekeeping tasks. This service cannot provide hands on nursing or medical care.

This service cannot be duplicative of any other service under the state plan or waiver. The case manager, CBCM, or integrated

health home care coordinator is responsible for authorizing the service and ensures that services provided during the time of Senior Companion provision do not coincide with similar services, IE respite, homemaker or chore. In addition, the case manager, CBCM, or integrated health home care coordinator is responsible to ensure that each provider understands the scope and timeframes for authorized tasks.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of service is 15 minutes. The member's service plan will tell how the member's health care needs are being met. Services must be authorized in the service plan. The Case manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Corporation for National and Community Services |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Senior Companion**

**Provider Category:**
Individual

**Provider Type:**
Corporation for National and Communitiy Services

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Senior Companion programs designated by the Corporation for National and Community Services.
Senior companion Programs are required to follow the Federal regulations, published in Title 45, Chapter XXV, Section 2551, of the Code of Federal Regulations (CFR). The Senior Companion Program was authorized under Title II, Section 211(b) of the Domestic Volunteer Services Act of 1973 (Public Law 93-113).

The program regulations require that project staff be covered by sponsor personnel policies [45 CFR 2551.25]. At a minimum, policies should address salaries and fringe benefits, probationary periods of service, suspensions, resignations, hours of service, annual and sick leave, holidays, terminations, and grievance procedures.

Compensation levels for project staff, including wages, salaries, and fringe benefits should be comparable to like or similar positions in the sponsor organization and/or in the project service area [45 CFR 2551.25(e)].

The sponsor should prepare a job description for each project staff position to promote the recruitment of qualified applicants and to specify each position's authority and responsibility. It is recommended that an annual performance evaluation be completed for all staff.

The National Service Criminal History Check Requirement, discussed below in Section 36.d in connection with selection of Senior Companions, also applies to project staff who have contact on a recurring basis with children, individuals age 60 and older, and persons with disabilities.

SEnior companion eligiblity:
1. Senior Companions must be 60 years of age or older and determined by a physical examination to be capable of serving the frail elderly or adults with special needs without physical detriment to either themselves or the adult served, and willing to abide by the program requirements.
2. Eligibility to be a Senior Companion may not be restricted on the basis of formal education; experience; race; religion; color; national origin, including limited English proficiency; sex; age; handicap; or political affiliation.
3.An individual who is registered, or required to be registered, on a State sex offender registry, is ineligible to serve. Grantees may adopt other disqualifying offenses. An individual who refuses to consent to a criminal registry check is also ineligible to serve. Individuals for whom the State criminal registry results are pending may be enrolled, but may not have unsupervised access to vulnerable populations until the results are complete.

Training:
1. The sponsor provides not less than 40 hours of orientation and training to Senior Companions – of which 20 hours must be pre-service orientation – and an average of four hours monthly of in-service training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Transportation

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

☐ **Service is not included in the approved waiver.**

**Service Definition** *(Scope)*:
Transportation services may be provided for members to conduct business errands, essential shopping, and to reduce social isolation. This service is offered in addition to medical transportation required under 42 CFR Section 431.53 and transportation services under the State plan defined at 42 CFR Section 440.170(a) and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
A unit of services is one mile or one one-way trip, or a unit established by a area agency on aging. The member's service plan will show how the member's health care needs are being met. Services must be authorized in the service plan. The case manager, CBCM, or integrated health home care coordinator will monitor the plan.

**Service Delivery Method** *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)*:

☑ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Subcontactor with Area Agency on Aging |
| Agency | Community Action Agencies |
| Agency | Regional Transit agency |
| Agency | Provider Contracting with NEMT |
| Agency | Nursing Facilities |
| Agency | Area Agencies on Aging |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency
**Provider Type:**
Subcontactor with Area Agency on Aging
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

Area Agencies on Aging as designated by the Department on Aging in 17—4.4(231).

4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if: a. The unit of general purpose local government can meet the requirements established to serve as

an area agency on aging pursuant to state and federal law; and b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following: a. An established office of aging operating within a planning and service area; b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit; c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose; d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or e. Any other entity authorized by the Older Americans Act.4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.
6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.
6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.
a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.
(1) The request for approvalshall be submitted to the department at least 30 days prior to the signing of the contract.
(2) All applicantsto provide servicesfor which the contract is proposed shall be listed on the request form.
b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency
**Provider Type:**
Community Action Agencies
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Iowa Code 216A.93 Establishment of community action agencies. The division shall recognize and assist in the designation of certain community action agencies to assist in the delivery of community action programs. These programs shall include but not be limited to outreach, community services block grant, low-income energy

assistance, and weatherization programs. If a community action agency is in effect and currently serving an area, that community action agency shall become the designated community action agency for that area. If any geographic area of the state ceases to be served by a designated community action agency, the division may solicit applications and assist the governor in designating a community action agency for that area in accordance with current community services block grant requirements

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Regional Transit agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
As designated by the Iowa Department of Transportation in the Code of Iowa 28M.
28M.1 Regional transit district defined.
"Regional transit district" means a public transit district created by agreement pursuant to chapter 28E by one or more counties and participating cities to provide support for transportation of passengers by one or more public transit systems which may be designated as a public transit system under chapter 324A.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education beyond those implemented by the contracting agency or provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers, CBCMs, and IHH care coordinators are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Provider Contracting with NEMT

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Transportation providers contracting with the non-emergency medical transportation broker.

Request for Proposal for Contract Award: The Broker will utilize Public Transit agencies, private transportation agencies and individuals. The network of providers may also include other transportation alternatives, such as the services of volunteers, taxis, wheelchair vans, stretcher vans, ambulances, and air ambulances (fixed wing and rotary). All transportation is to be provided with an occupant protection system that addresses the safety needs of the disabled or special needs individuals.
The Broker will be required to ensure that all eligible Medicaid Members receive transportation services that are safe, reliable and on time by providers who are licensed, qualified, competent, and courteous.

The Department's Contract Administrator for the IME is the principal contact with the transportation Broker. The Department's Contract Administrator is responsible for monitor the contract performance and compliance with contract terms and conditions.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Nursing Facilities

**Provider Qualifications**

**License** *(specify)*:
Nursing facilities defined in IAC 441 Chapters 81 :
"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

**Certificate** *(specify)*:

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**
Agency

**Provider Type:**
Area Agencies on Aging
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Area Agencies on Aging as designated by the Department on Aging in 17—4.4(231).

4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or dedesignates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if: a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following: a. An established office of aging operating within a planning and service area; b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit; c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose; d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or e. Any other entity authorized by the Older Americans Act.4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
**Frequency of Verification:**
Every four years

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  *Check each that applies:*
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3). prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:
1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a."Consumer" means an individual approved by the department to receive services under a waiver.
b. "Provider" means an agency certified by the department to provide services under a waiver.
c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department(Department of Human Services) shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include Iowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Iowa Department of Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

1. For purposes of this section and section 249A.30 unless the context otherwise requires:
a. "Consumer" means an individual approved by the department to receive services under a waiver.
b. "Provider" means an agency certified by the department to provide services under a waiver.
c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All others services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the IME Provider Services prior to enrollment as a Medicaid provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding

of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ( ) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- (●) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

A person who is legally responsible for a member may provide services to a waiver member. This applies to guardians of their adult children and not to a minor child. The person who is legally responsible for a member may be a Consumer Directed Attendant Care (CDAC) provider or an employee under the Consumer Choices Option (CCO) program. There are no limitations on the types of services provided; however, when the legally responsible person is the CDAC or CCO provider, the service planning team determines the need for and the types of activities to be provided by the legally responsible person. This includes reviewing if the needed services are "extraordinary." Any services which are activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and are not necessary to assure the health and welfare of the member and to avoid institutionalization would not be considered extraordinary. If the legal representative is an employee through CDAC or CCO, the relative or legal guardian must have the skills needed to provide the services to the member. In many situations, the member requests the guardian to provide services, as the guardian knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

Through the person-centered planning process, the comprehensive service plan is developed. If the member has a guardian or attorney in fact under a durable power of attorney for health care who is also their service provider, the care plan will address how the case manager, health home coordinator, or community-based case manager will oversee the service provision to ensure care is delivered in the best interest of the member.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's plan of care that is authorized and monitored by a case manager, health home coordinator, or community-based case manager. Service plans are monitored to assure that authorized services are received.

For fee-for-service members, the State completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers. In addition, information on paid claims for fee-for-service members are available in ISIS for review. The ISIS system compares the submitted claims to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan.

MCOs are responsible for ensuring the provision of services by a legally responsible individual is in the best interest of the member and that payments are made only for services rendered. All representatives must participate in a training program prior to assuming self-direction, and MCOs provide ongoing training upon request and/or if it is determined a representative needs additional training. MCOs monitor the quality of service delivery and the health, safety and welfare of members participating in self-direction, including implementation of the back-up plan. If problems are identified, a self-assessment is completed to determine what additional supports, if any, could be made available. MCOs must ensure payments are made only for services rendered through the development and implementation of a contractually required program integrity plan. The DHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

Per to 441 Iowa Administrative Code 79.9(7):
"a. Except as provided in paragraph 79.9(7)'b,' medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.
b. Notwithstanding paragraph 79.9(7)'a,' medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

☑ **Self-directed**

☐ **Agency-operated**

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A member's relative or legal guardian may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the member. Legal representative means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger. The relative or legal guardian may be an Individual CDAC provider, a member under the CCO program, or an employee hired by a provider agency. There are no limitations on the types of services provided, however, when the relative or legal guardian is the CDAC or CCO provider, the case manager, integrated health care coordinator, or community-based case manager, and interdisciplinary team determine the need for and the types of activities provided by the relative or legal guardian. If the relative or legal guardian is an employee of a provider agency, it is the responsibility of the provider to assure the relative or legal guardian has the skills needed to provide the services to the member.

Whenever a legal representative acts as a provider of consumer-directed attendant care, the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event. In many situations, the member requests the guardian provide services, as the guardian knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's service plan that is authorized and monitored by the member's case manager, integrated health care coordinator, or community-based case manager.

Case managers, integrated health care coordinators, and community-based case managers are responsible to monitor service plans and assure the services authorized in the member's plan are received. In addition, information on paid claims of fee-for-service members is available in ISIS for review. The ISIS System compares the submitted claim to the services authorized in the service plan prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. The state also completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers and provider agencies. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

Per to 441 Iowa Administrative Code 79.9(7):
"a. Except as provided in paragraph 79.9(7)"b," medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.
b. Notwithstanding paragraph 79.9(7)"a," medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case mangers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. For the first two years of an MCO contract, the entity must give all 1915(c) HCBS waiver providers, which are currently enrolled as Iowa Medicaid providers, the opportunity to be part of its provider network. During this time period, the MCO may recommend disenrollment of providers not meeting defined performance measures. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

After the 2-year initial period of the MCO contract, the State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating

rationales for not having providers in their networks. While the number of providers not contracted with all three managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Qualified Providers**

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.***

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**QP-a1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: Contracted Entity | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |

| | | |
|---|---|---|
| | | |
| | Other<br>Specify: | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other<br>Specify: | Annually |
| | Continuously and Ongoing |
| | Other<br>Specify: |

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.**

| Responsible Party for data collection/generation*(check each that applies):* | Frequency of data collection/generation*(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☑ Other<br>Specify:<br>Contracted Entity | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☐ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☐ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:
**Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.**

| Responsible Party for data collection/generation *(check each that applies)*: | Frequency of data collection/generation *(check each that applies)*: | Sampling Approach *(check each that applies)*: |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☐ Operating Agency | ☑ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☑ Other<br>Specify:<br>Contracted Entity | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☐ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis *(check each that applies)*: |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☐ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☐ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.
All MCO providers must be enrolled as verified by IME Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not

correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies)*: | **Frequency of data aggregation and analysis***(check each that applies)*: |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>contracted entity and MCO | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  *Furnish the information specified above.*

- **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  *Furnish the information specified above.*

- **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  *Furnish the information specified above.*

- **Other Type of Limit.** The State employs another type of limit.
  *Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1. Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Detailed information and timelines for the HCBS Settings project are included in Attachment #2 HCBS Settings. The Iowa Medicaid Enterprise received initial CMS approval for Iowa's statewide HCBS transition plan on August 10, 2016.